NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
Bee Hive Homes of Evanston	1949 W. Uinta Street Evanston, WY 82930	7/16/2008

SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE
A survey was conducted at your facility on July 16, 2008 by the Office of Healthcare Licensing and Surveys (OHLS). **Rules and Regulations for Licensure of Assisted Living Facilities** **Section 6.** Furnishings, Building, Physical Plant. **(i)** All drapery and curtains shall be flame retardant. *This regulation was NOT MET as evidence by:*	POC ACCEPTED W/ FOLLOWUP PARKER ON 8/29/08 The facility will ensure that all curtains in the facility will be sprayed with a fire retardant spray once a year.	
A. Based on observation, staff interview and record review the facility failed to ensure window curtains were flame retardant in two of two smoke compartments. The findings were: 1. Observation on 7/16/08 between 9:45 AM and 11 AM revealed the following locations had window curtains that were not flame retardant: a. The business office. b. The front lobby. 2. Interview with the director on 7/16/08 at 9:47 AM revealed none of the curtains in the facility were flame retardant. She further reported that she was unaware the curtains were required to be flame retardant. However review of the facility's "Fire/Disaster Plan," section S revealed "...drapes and curtains will be flame retardant."	Each set of curtains will have a tag attached indicating location of curtains, description of curtains and date applied. A log sheet will be kept to record that this has been done each year. The Director will be responsible for compliance with this standard. Date of Completion. September 12, 2008	

Florence J Parks, Director RECEIVED 8-15-08
Provider Representative's Signature/Title AUG 15 2008 Date

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Rules and Regulations for Licensure of Assisted Living Facilities

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.

This regulation was NOT MET as evidence by:

B. Based on observation and staff interview the facility failed to ensure resident room corridor doors were provided with latches suitable for keeping the doors closed and failed to maintain automatic-closing devices in one of two smoke compartments. The findings were:

1. Observation on 7/16/08 at 9:55 AM revealed the automatic closing device attached to the west smoke barrier door did not latch the door into its frame with three attempts.

2. Observation on 7/16/08 at 10:24 AM revealed the corridor door to resident room #1 did not latch into its frame, with three attempts. Interview with the director at the time of observation revealed none of the corridor doors were routinely inspected.

The facility will ensure that all doors will latch into its frame.

All of the doors in the facility were inspected and adjustments were made so that all the doors latch properly into its frame.

A log sheet will be kept to record that this has been done ~~each year~~. QUARTERLY.

The Director will be responsible for compliance with this standard.

Date of Completion. July 28, 2008

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*Reference **NFPA 101** Life Safety Code, 1994 Edition:*
"22-2.3.6.3 Doors shall be provided with latches or other mechanism suitable for keeping the doors closed. No doors shall be arranged to prevent the occupant from closing the door."
"31.1.3.1 Whenever of wherever and device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of the Code, such device, equipment, condition, arrangement, level of protection, or other feature shall be thereafter permanently maintained unless the Code exempts such maintenance."

8/29/08

C. Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas by smoke resistant partitions in one of two smoke compartments. The findings were:

1. Observation on 7/16/08 at 9:58 AM revealed neither of the laundry room's two corridor doors were equipped with automatic-closing devices. Further review revealed one of the two doors did not latch into its frame with three attempts.
2. Observation on 7/16/08 at 10:35 AM revealed paper products were stored on shelves from floor to ceiling in the back storeroom. The corridor door to the room was not equipped with an automatic-closing device.
3. On 7/16/08 at 9:58AM interview with the director revealed she was unaware doors to hazardous areas required automatic-closing devices.

The facility will ensure that all hazardous areas are separated from use areas by smoke resistant partitions.

Both of the laundry room's two corridor doors have been installed with automatic-closing devices and both of these doors latch properly into its frame.

The back storeroom door has been installed with an automatic-closing device.

The Director will be responsible for compliance with this standard.

ALL HAZARDOUS AREAS WILL BE INSPECTED QUARTERLY TO ENSURE SEPARATION.

Date of Completion. August 3, 2008

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*Reference **NFPA 101** Life Safety Code, 1994 Edition:*
"22-2.3.2 Hazardous Areas. Any hazardous area shall be protected in accordance with the following:

(a) Any hazardous area that is on the same floor as, and is in or abuts a primary means of escape or a sleeping room, shall be protected be either:

1. Automatic sprinkler protection, in accordance with 22-2.3.5, or the hazardous area and a separation that will resist the passage of smoke between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic-closing in accordance with 5-2.1.8. "

Wasatch Fire Protection, who does our fire inspection, will be on the facility on August 21, 2008 and will check the sprinkler and provide a solution on meeting the required distance for the sidewall sprinkler head in the kitchen. (1)

D. Based on observation, record review and staff interview the facility failed to ensure the sprinkler system was properly installed in one of two smoke compartments and failed to properly test two of two sprinkler system devices. The findings were:

1. Observation on 7/16/08 at 9:52 AM revealed the sidewall sprinkler head in the kitchen above the refrigerator was more than the allowed distance from the far wall. The sidewall sprinkler head was actually 19 feet 8 inches from the far wall. Interview with the director at the time of observation revealed the sprinkler system was not inspected annually for proper spacing.

Wasatch Fire Protection will test our equipment on a quarterly basis. They will be at our facility on August 21, 2008.

A log sheet will be kept to record that this testing is done on a quarterly basis.

The Director and the Owner will be responsible for compliance with this standard.

Date of Completion. September 12, 2008

2. Review of the sprinkler system testing records revealed the waterflow and maindrain devices were not being tested quarterly. The system was only

(1) EITHER THE FACILITY WILL ADD A NON SPECIAL HEAD W/ PLATE REMOVED OR. THE FACILITY WILL INSTALL AN EXTENDED COVERAGE HEAD IN THE EXISTING SIDE-WALL LOCATION.

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being tested annually. Records show the system was last tested on October 30, 2007.

3. Interview with the director on 7/16/08 at 11:30 AM revealed she was unaware the sprinkler system required quarterly testing.

*Reference **NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, 1994 Edition.***

"2-5.1.4.2 The maximum distance between sprinklers shall not exceed 12 ft. and the maximum distance to a wall or partition shall not exceed 6 ft."

"NFPA 25, Standard for the Inspection, Testing, and Maintenance of the Water-Based Fire Protection systems, 1992 edition"

"2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign material, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation."*

"2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit."

"2-4.1.5 The stock of Spare Sprinklers

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shall be as follows:
(a) Under 300 sprinklers, no fewer than 6 sprinklers
(b) 300-1000 sprinklers, no fewer than 12 sprinklers...."
"9-2.6 Main Drain Test. A main drain test shall be conducted quarterly at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves."*
"9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacturer's instructions."

8/29/08

E. Based on observation and staff interview the facility failed to ensure ashtrays were of a safety-type design. The findings were:

Observation on 7/16/08 at 10:38 AM revealed the ashtray on the back patio was the open bowl design, and cigarette butts were left in the top of the ashtray. Interview with the director at the time of observation revealed the ashtray was only emptied once a week. She further reported that cigarette butts were found outside of the ashtray when it was windy.

Reference NFPA 101 Life Safety Code, 1994 Edition:
"31-7.4 Smoking. Where smoking is permitted, noncombustible safety-type ashtrays or receptacles shall be provided in convenient locations."

The facility will ensure that a proper noncombustible safety-type ashtray/receptacle will be provided for the back patio where smoking is permitted.

Smokers will also be instructed to make sure that they are disposing of their cigarette butts in this safety-type ashtray. This safety-type ashtray will be emptied on a weekly basis. A log sheet will be kept to record that this is being done on a weekly basis.

The Director will be responsible for compliance with this standard.

Date of Completion. September 12, 2008

F. Based on record review and staff interview the facility failed to ensure five of six fire alarm system components were tested as required.

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The findings were:

1. Review of the fire alarm system testing records revealed the main fire alarm control panel had not been tested on a quarterly basis as required.
2. Review of the fire alarm system testing records revealed the alarm system batteries, alarm notification appliances and smoke detectors had not been tested annually.
3. Review of the fire alarm system testing records revealed the smoke detector sensitivity test had not been conducted on a bi-annual basis.
4. Interview with the director on 7/16/08 at 11:30 AM revealed the system had not been tested for at least the past five years.

Mountain Alarm has been contacted and they will test the ~~necessary electrical systems~~ FIRE ALARM PANEL. quarterly.

A log sheet will be kept to record that this Testing is done on a quarterly, annual and bi-annual basis.

The Director and the Owner will be responsible for compliance with this standard.

Date of Completion. September 12, 2008

5. Review of the fire alarm system testing records revealed the smoke detectors in the resident rooms were hard wired to the building's electrical system. Each detector was also equipped with a 9-volt battery. The director reported the batteries were not replaced on a routine basis.

"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,*

Date of Completion. September 12, 2008

The facility will ensure that all smoke detectors (18) in the facility will be replaced with new 9-volt batteries each year.

A log sheet will be kept to record that this has been done each year.

The Director will be responsible for compliance with this standard.

Date of Completion: August 3, 2008

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quarterly *f. Transponders, quarterly* *"6. Batteries-Fire alarm systems* *d. Sealed Lead-Acid Type* *1. Charge Test (Replace batteries every 4 years.), annually* *2. Discharge Test (30 minutes), annually* *3. Load Voltage Test, semi-annually* *"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* *k. Waterflow Devices, quarterly* *"19. Alarm Notification Appliances"* *a. Audible Devices, annually* *c. Visible Devices, annually*	The facility will ensure that there will be no 3-way adapters used in the facility. The two 3-way adapters that were found by the safety inspector have been removed. A power surge box was installed in Room #6. The Director will be responsible for compliance with this standard. ELECTRICAL SYSTEM WILL BE INSPECTED QUARTERLY TO ENSURE TEMPORARY WIRING IS NOT BEING USED. Date of Completion: July 18, 2008	8/29/08
G. Based on observation and staff interview the facility failed to ensure the electrical system was properly installed and maintained in two of two smoke compartments. The findings were: 1. Observation on 7/16/08 at 10:40 AM revealed the television set in resident room #6 was plugged into a 3-way adapter. Interview with the director at the time of observation revealed the electrical system was not routinely inspected. 2. Observation on 7/16/08 between 9 AM and 11 AM revealed none of the electrical receptacles in the resident toilet rooms or the shower room receptacles were provided with ground fault circuit interrupters. Interview with the director at 10:48	The facility will ensure that all GFI outlets will be installed by an electrician in the resident toilet rooms and the main shower room. The Director and the Owner will be responsible for compliance with this standard. Date of Completion: September 12, 2008	

AM revealed she was unaware if the electrical circuit supplying power to the receptacles in the circuit panel were GFCI circuits.

"NFPA 70, National Electrical Code, 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;
(4) Where attached to building surfaces;"
"517-20. Wet Locations.
(a) All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection...."

Program Administration of Assisted Living Facilities

Section 7, Assisted Living Facility (ALF) Core Services.
(n) Furnishings, Buildings, Physical Plant.
(i) One half of the licensed beds shall be private rooms;
(ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below;
(Z) Portable space heaters shall not be used, (e.g. electric or kerosene).

This regulation was NOT MET as evidenced by:

H. Based on observation and staff interview the facility failed to ensure portable space heaters were prohibited in two of two smoke compartments. The findings were:

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1. Observation on 7/16/08 between 10 AM and 11 AM revealed the following locations had prohibited portable space heaters:
   a. Resident room #2.
   b. Resident room #10.
2. Interview with the director on 7/16/08 at 10:27 AM revealed she was aware the space heaters were in use. She further reported that she was aware space heaters were prohibited.

Program Administration of Assisted Living Facilities

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);

(4.) Residents who participated including staff and family members;

(5.) Time required (minutes and

The facility will ensure that the use of portable space heaters will not be used in the facility.

The space heaters that were found in Resident Room #2 and Resident Room #10 have been removed.

The Director will be responsible for compliance with this standard.

THE FACILITY WILL BE INSPECTED SEMI-ANNUALLY TO ENSURE SPACE HEATERS ARE NOT USED.

~~Date of Completion: July 18, 2008~~

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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:

I. Based on record review and staff interview the facility failed to ensure fire drills were held on each shift during each quarter and failed to evacuate every resident during 12 of the past 12 months. The findings were:

1. Review of the fire drill testing records revealed a drill had not been conducted on the first shift (7 AM-3 PM) during the second quarter of 2008.
2. Review of the fire drill testing records revealed a drill had not been conducted on the second shift (3 PM-11 PM) during the first and second quarters of 2008.
3. Review of the fire drill testing records revealed a drill had not been

The facility will ensure that all residents are evacuated from the building during fire drills (including Hospice residents).

The facility will also ensure that a minimum of one drill is conducted each quarter on each shift. A log sheet will be kept to record that this is being done. The facility will also ensure that two drills will be schedule each year while residents are asleep – August 16, 2008 and December 16, 2008. A log sheet will be kept to record that this is being done.

The facility has a maximum of 13 minutes to evacuate all residents from the facility. Our records indicate that only once during fire drills conducted in 2008 that it took 15 minutes to evacuate all residents. The facility will continue to improve on the time it takes to evacuate all residents.

The fire drills referred to in the deficiency report indicated that on July 4, 2007, that the residents were not involved in the drill. The fire drill record does indicate that the residents were involved – the residents were on the front patio for a bar-b-que and the anticipated fire was started by flames from the grill starting the side of the building on fire – all residents practiced going to the end of the driveway. The fire drill on May 27, 2008, also involved the residents but was not reported correctly. The fire drill for June 2008 was conducted on June 30, 2008 on the 3 to 11 shift but the report had not yet been filled out when the safety inspector was here. The staff training drills are incorporated with the resident fire drills at all times.

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conducted on the third shift (11 PM -7 AM) during the third quarter of 2007. 4. Review of the fire drill testing records revealed none of the fire drills held on the third shift occurred while residents were sleeping. The Life Safety Code, National Fire Protection Association (NFPA) 101, requires two drills be scheduled each year while residents are asleep. 5. Review of the fire drill testing records revealed at least one resident had not been evacuated during each monthly fire drills over the past year. Interview with the director revealed she was aware the residents were not evacuated because they were on hospice. She also reported that she knew all residents were supposed to be evacuated, but she would not evacuate hospice residents. She further reported that the facility's evacuation capability was "slow". 6. Review of the fire drill testing records revealed the fire drills held on July 4, 2007 and May 27, 2008 had been staff training drills were only staff members were involved and residents were not evacuated. Further review showed a fire drill had not occurred during the month of June 2008. Interview with the director revealed she was unaware staff training drills could not be used as fire drills. 7. Review of the fire drill testing records revealed none of the fire drills that occurred in the past year had the	The facility will ensure that all fire drills conducted will include the minutes and seconds it takes for evacuation. A log sheet will be kept to record that this has been done each month. The Director will be responsible for compliance with these standards. Date of Completion: August 16, 2008 ~~and December 16, 2008.~~ The Director will be responsible for compliance with this standard.	8/29/08

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minutes and seconds recorded for evacuation. The drills only had the minutes recorded.

NFPA 101 *Life Safety Code, 1994 Edition:*

"31-7.3 Fire Exit Drills. Fire exits drills shall be conducted at least six times per year on a bi-monthly basis with a minimum of 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 the experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of this Code for board and care facilities.

A-22-1.3 Evacuation Capability. The evacuation capability of the residents and staff is a function of both the ability of the residents to evacuate and the assistance provided by the staff. It is intended that the evacuation capability be determined by the procedure acceptable to the authority having jurisdiction. It is also intended that the timing of drill, the rating of residents, and similar actions related to determining the evacuation capability be performed by persons approved by or acceptable to the authority having jurisdiction. The evacuation capability can be determined by the use of the definitions in 22-1.3, the application of NFPA 101M, Manual of Alternative Approaches to Life Safety, Chapter 5, or a program of drills (timed). Where drills are used in determining evacuation capability, it is suggested that the facility conduct and record fire drills

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12 times per year (four times per year on each shift), and that the facility conduct the drills in consultation with the authority having jurisdiction. Records should indicate the time taken to reach a point of safety, date and time of day, location of simulated fire origin, the escape paths used, and comments relating to residents who resisted or failed to participate in the drills. Translation of drill to evacuation capability may be determined as (1) 3 minutes of less, prompt; (2) over 3 minutes, but not in excess of 13 minutes, slow; and (3) more than 13 minutes, impractical. Evacuation capability in all cases is based on the time of day or night when evacuation of the facility would be most difficult (e.g., sleeping residents or fewer staff present). Where the facility management does not furnish an evacuation capability determination acceptable to the authority having jurisdiction, the evacuation capability should be classified as impractical. However, evacuation capability should be considered slow if the following conditions are met: **(a)** *All residents are able to travel to centralized dining facilities without continuous staff assistance, and* **(b)** *There is continuous staffing whenever there are residents in the facility.*		Ø