NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
HOMESTEAD ALF	950 HOMESTEAD AVE, RIVERTON WY 82501	02/2-4/09

SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE

The initial Health and Life Safety Code survey for Assisted Living Facilities (ALF) was conducted at your facility by the Office of Healthcare Licensing and Surveys (OHLS) on 2/2-4/09. 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 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.

This REGULATION was not met as evidenced by:

1. Based upon observation and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13. The findings were:

Observations on 2/3/09 and 2/4/09 revealed the following concerns:

a. Sprinkler head escutcheons were not flush (greater that one inch gap) with the ceiling in the following locations: resident rooms #36 and #37 and resident bathrooms #10 and #33. In addition, the smoke detector in resident room #20 was not flush with the ceiling, ie greater than one inch gap.
b. Sprinkler head escutcheons were missing

At time of this response issues with the escutcheons identified in bathrooms # 10 & # 23, hallways at rooms # 7 & #8 and # 38 & # 39, hallway at room #33 were corrected on 2/17/09.

Smoke detector in room #20 refastened.

#33 Rooms #36, #37, #20 Smoke detector

2/17/09

M C Christensen RN — doc = 4/15/09 — 3-12-09
Provider Representative's Signature/Title — Date

on 3/19/09 Kristen Jones, Accepted per A's made w/ Mary Ellen RN fax needs to Remain attached.

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from the ceiling in the following locations: the hallway between resident rooms #7 and #8 and between resident rooms #38 and #39, the main janitor's closet and the dry storage room in the kitchen.
c. The hallway ceiling above entry to resident room #33 had a 1-inch square hole cut into the drywall next to the ceiling escutcheon. The facility's maintenance manager confirmed the above observations.

Reference NFPA 101 Life Safety Code, 1994 Edition 22-3.3.5.1 All buildings shall be protected throughout by an approved, automatic sprinkler system installed in accordance with section 7-7.... 7-7.1.1 Each automatic sprinkler system required by another section of the Code shall be installed in accordance with NFPA 13, "NFPA 13 Standards for the Installation of Sprinkler Systems. 6.2.7.2 Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly.

Issues with the escutcheons identified to room #36, #37, the janitor closet, and kitchen dry storage require major corrective action. We have agreement with a sprinkler contractor to be on site to investigate situation by March 20, 2009 and seek solution by April 5, 2009.

4/05/09

The maintenance director will complete quarterly observation of all escutcheons and repair any deficiencies as soon as possible. All deficiencies shall be reported at the monthly QA meeting.

2. Based upon observation and staff interview, the facility failed to ensure the following hazardous locations had operational self-closing devices. The findings were:

Observation showed the laundry room door and the door to the large storeroom in the activities room did not latch in their respective frames with three attempts.

Reference NFPA 101 Life Safety Code, 1994 Edition 22-3.3.6.6 Doors in walls required by 22-3.3.6.1 and 22-3.3.6.2 shall be self closing or automatic-closing in accordance with 5-2.1.8. Doors in walls separating sleeping rooms from corridors shall be automatic-closing in accordance with 5-2.1.8. Exception No. 2: In buildings protected throughout by an approved, automatic sprinkler system installed in accordance with 22-3.3.5, doors, other than doors to hazardous areas, vertical openings, and exit enclosures, shall not be required to be self-closing or automatic-closing. 5-2.1.8 Self-Closing Devices. A door designed to normally be kept closed in a means of egress, such as a door to a stair enclosure or horizontal exit, shall be

Doors - Additional door closures were added to subject doors.

2/19/09

The staff will report any deficiencies noted in the self-closing doors in the facility to the administrator and/or maintenance director for immediate repair. All deficiencies will be reported at the monthly QA meeting.

See Fax attached for additional info

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a self-closing door and shall not be secured in the open position at any time.

Chapter 12. Section 7. Assisted Living Facilities (ALF) Core Services.

(b) Resident Assessment and Services.
(iii) The Registered Nurse shall make an initial assessment of the resident's needs, which describes the resident's capability to perform ADL's and notes all significant impairments in functional capability.
(vi) Resident Assistance Plan.
A. An RN shall develop an assistance plan for each resident.

This REGULATION was not met as evidenced by:

Based on medical record review and staff interview the facility failed to complete an admission assessment or an assistance plan for 2 (#1, #4) of 4 sample residents. The findings were:

1. Record review revealed resident #1 was admitted to the facility on 11/25/05. The resident's record did not contain an admission nursing assessment or an assistance plan.
2. Record review revealed resident #4 was admitted to the facility on 2/08/02. The resident's record did not contain a nursing admission assessment or an assistance plan.

Interview with the facility administrator on 2/04/09 verified the aforementioned residents' records did not have a nursing assessment or assistance plan.

(e) Resident Records and Reports.
(i) Each folder shall include the following:
(B) History and physical performed by a physician
(C) Individual Admission form

This REGULATION was not met as evidenced by:

At the time of this response the registered nurse has completed a nursing assessment and assistance plan on resident # 1 and # 4. — 3/9/09

The registered nurse will complete a nursing assessment and assistance plan on current residents of the facility; including all additional admissions. All assistance plans will be developed and individualized by all disciplines and overseen by the registered nurse. — 4/5/09
The day charge nurse will monitor the completion of nursing assessment and individualization of assistance plans of current and new admissions. All deficiencies will be reported to the administrator for immediate corrective action. Findings will be reported at the monthly QA meeting.

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Based on record review and staff interview the facility failed to ensure 2 of 4 sample resident's (#1, #4) had the required admission documentation in their records. The findings were:

Record review revealed resident #1 was admitted to the facility on 11/25/05. The record did not have an individual admission form or a history and physical.
Record review revealed resident #4 was admitted to the facility on 2/08/02. The resident's record did not contain an individual admission form or a history and physical.

Interview with the facility administrator on 2/04/09 verified the aforementioned residents' records lacked the required individual admission forms and history and physical forms.

The registered nurse has completed an individual admission form in addition to having a current history and physical completed by a physician on both resident #1 and #4 at time of this response.

The charge nurse will ensure an individual admission form and a history and physical are completed on all residents prior to admission to this facility.
The charge nurse will monitor the completion of all current and new admissions using a checklist for admission forms.
All deficiencies will be reported to the administrator for immediate corrective action and presented at the QA meeting monthly.

3/9/09

(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.
(L) Personnel Policies
(M) Grievance Procedures
(R) Identification and notification of change in resident's condition

This REGULATION was not met as evidenced by:

Based on review of facility documentation and staff interview, the facility failed to develop all required policies and procedures. The findings were:

Review of the facility policies and procedures revealed no admission, transfer and discharge policy, no personnel policies, no grievance procedures and no identification and notification of change in resident's condition policies.

Interview with the facility's administrator on

At the time of response the facility has completed grievance, resident change of status, admission/transfer/discharge, and core personnel policies for the facility.

The administrator and charge nurse will educate the staff on policies and monitor compliance. All deficiencies will be reported to administrator for immediate corrective action and monitored at the QA monthly meeting.

3/12/09

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2/4/09 verified the facility's policies and procedures were still being developed.

(o) Evacuation Capability, Emergency Procedures, and Fire Safety.
(iii) Fire Safety.
(A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers.

This REGULATION was NOT MET as evidenced by:

Based on observation and staff interview, the facility failed to inspect 11 of 11 portable fire extinguishers in accordance with NFPA 101, Section 22.3.3.5.3, 7-7.4.1, and NFPA 10, Section 4-3.1. The findings were:

Review of the facility's records revealed one fire extinguisher (south wing) was not inspected during October, November or December 2008; one fire extinguisher (Great Room #3) was not inspected during the month of December 2008, and the remaining fire extinguishers were not inspected during November and December 2008.

The facility administrator confirmed the records indicated the above fire extinguishers were not inspected for the months indicated.

Reference NFPA 101 Life Safety Code, 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"
"4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals...."

(o) Evacuation Capability, Emergency Procedures, and Fire Safety.
(iii) Fire Safety.

This condition was noted by the acting administrator when the fire extinguisher inspection was conducted for January 2009. That being the case, it was our rationale that "currency of inspection" is the essence, not what didn't happen. Could have "penciled in" those missing check points, but that is not reality. Reality is, the need to pay more attention to this detail and that is what we are doing.

See Attached Fax

delete

1/2009

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(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. This REGULATION was not met as evidenced by: Based upon record review and staff interview, the facility failed to conduct one fire drill on each shift per quarter. The findings were: During the previous year twelve fire drills were conducted. However, during the first quarter (January, February, March) of 2008 all drills were conducted during the day shift. During the next three quarters, fire drills were conducted once a month during the morning, the afternoon and the evening shifts. The facility administrator confirmed the fire drill records were accurate.	**At the time of this response the facility is in accordance with the fire drill regulations.** **The maintenance director will ensure fire drills will be completed at least twelve times per year with one drill conducted each quarter on each shift.**	2/27/09