Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF009	A. BUILDING _____ B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSAROKA ASSISTED LIVING COMMUNITY	2401 COUGAR AVENUE CODY, WY 82414

(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		

A Life Safety Code survey was conducted at your facility on January 30-31, 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 2003. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 51 licensed beds and a total census of 47 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, 2000 Edition, unless otherwise noted.

This regulation was NOT MET as evidence by:

A. Based on observation and staff interview, the facility failed to ensure hazardous areas were

The following is Absaroka Senior Living Plan of Correction to the Department of Health Services regarding Statement of Deficiencies dated 1-24-12 and received at the community via e: mail on 1-27-12. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions outlined in the Statement of Deficiencies, or proposed administrative penalty (with the right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or findings. We have not presented all contrary factual or legal arguments, nor any mitigating factors.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Kathleen Schultz, ED (X6) DATE 3-2-12

STATE FORM 6899 5L611 If continuation sheet 1 of 6

POC ACCEPTED W/ KATHLEEN SCHULTZ, ED, ON 4/11/12.

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SALF	Continued From page 1 separated from use areas in 1 of 3 smoke compartments. The findings were: Observation of the laundry room on 1/30/12 at 5:17 PM showed the corridor door was propped open with a kick down lever attached to the bottom of the door. At the time of the observation the maintenance director reported he was aware hazardous area corridor doors were prohibited from being held open unless they automatically closed with the activation of the fire alarm system. He could not explain why the kick down lever had not been noticed and removed during the quarterly inspections. Reference, 32.3.3.2.2; 8.2.4.3.5 Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. --- B. Based on observation and staff interview, the facility failed to ensure manual fire pull stations were unobstructed in 1 of 3 smoke compartments and failed to post a current central station certificate. The findings were: 1. Observation of the north smoke compartment on 1/30/12 at 4:32 PM showed the pull station near the northwest exit was obstructed by a table and three plants sitting on top of the table. At the time of the observation the maintenance director reported he was aware pull stations are required to be unobstructed at all times. He further reported the table was moved because the carpet was currently being replaced. Observation at that time showed not items were stored against the opposite wall. 2. Observation of the fire alarm control panel on	SALF	1. **Corrective Action:** The doors that require self-closing or automatic-closing have been identified and do not have door stops or kick levers. 2. **Systemic Change:** An in-service has been set up on 3-07-12 at our staff meeting for the Director of Maintenance to review the code and identify the doors affected to ensure compliance. 3. **Monitoring:** Checklist has been developed to monitor weekly door checks times one month and monthly there after. 4. **Date of Completion:** March 30, 2012 1. **Corrective Action:** The facility staff shall ensure manual pull stations are unobstructed. 2. **Systemic Change:** An in-service has been set up on 3-7-12 at our staff meeting for the Director of Maintenance to review the code and identify the pull stations and panels to ensure compliance. 3. **Monitoring:** Checklist has been developed to monitor pull stations and panels monthly. 4. **Date of Completion:** March 30, 2012	

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SALF	Continued From page 2 1/30/12 at 5:32 PM showed the central station certificate that was posted near it had expired on 3/31/11. At the time of the observation the maintenance director reported he had assumed the fire alarm contractor had replaced the certificate with the last inspection. He also reported that he did not ensure the certificate was update on an annual basis. Reference, 31.3.4.2.1; 9.6.2.6* Each manual fire alarm box on a system shall be accessible, unobstructed, and visible. 32.3.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 5-2.2.3.1.1 Fire alarm systems providing services that complies with all the requirements of this code shall be certified by the organization that has listed the central station, and a document attesting to this certification shall be located on or within 36 in. of the fire alarm system control unit or, if no control unit exists, on or within 36 in. of a fire alarm system component. --- C. Based on observation and staff interview, the facility failed to ensure a sprinkler wrench was provided for maintenance of the sprinkler system. The findings were: Observation of the spare sprinkler cabinet on 1/30/12 at 5:09 PM showed a sprinkler wrench was not provided to replace sprinkler heads. At the time of the observation the maintenance director reported he assumed the sprinkler contractor would have supplied the cabinet with all needed equipment. He also reported he was unaware a sprinkler wrench was required. Reference, 32.3.3.5.1, 9.7.5, NFPA 25, 1999	SALF	(B2) 1. **Corrective Action:** Central station fire alarm certificate shall be reviewed annually for compliance. 2. **Systemic Change:** The Director of Maintenance to place on annual check list to ensure certificate is current. 3. **Monitoring:** The Director of Maintenance will place on annual check list to ensure compliance. 4. **Date of Completion:** March 30, 2012 (C) 1. **Corrective Action:** The special sprinkler wrench will be provided and kept in the sprinkler cabinet to be used for removal and installation of sprinklers. 2. **Systemic Change:** The Director of Maintenance shall ensure appropriate placement in the cabinet of the special sprinkler wrench. 3. **Monitoring:** The Director of Maintenance will place on the annual checklist to ensure compliance. 4. **Date of Completion:** March 30, 2012	

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SALF	Continued From page 3 Edition; 2-4.1.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed. --- D. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 3 smoke compartments. The findings were; Observation of the electrical system on 1/30/12 at 5:12 PM showed the computer in the medication room was plugged into two surge protector's in-line. At the time of the observation the maintenance director could not explain why the surge protector's had not been noticed and rearranged during the quarterly inspections. Reference, 18.5.1.1, 9.1.2, NFPA 70, 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 (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	SALF (D)	1. **Corrective Action:** Temporary electrical wiring will not replace permanent fixed wiring. 2. **Systemic Change:** a) An in-service has been set up on 3/7/12 at our staff meeting for the Director of Maintenance to review this code for compliance. b) Quarterly reminder will be placed in the newsletter directed to residents and families regarding this code. 3. **Monitoring:** The Director of Maintenance will inspect rooms and offices and will place on the quarterly check list to ensure compliance. 4. **Date of Completion:** March 30, 2012	

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SALF	Continued From page 4 Section 7. Assisted Living Facility (ALF) Core Services. (n) Furnishings, Buildings, Physical Plant. (ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below; (M) The facility shall be maintained so that it is free of hazards, such as loose or broken window glass, loose or cracked floors or floor coverings, or cracked or loose plaster on wall or ceilings; This regulation was NOT MET as evidence by: E. Based on observation and staff interview, the facility failed to ensure oxygen cylinders were properly secured in 1 of 3 smoke compartments. The findings were: Observation on 1/30/12 at 5:01 PM showed resident room #46 had two "E" size oxygen cylinders standing upright and unrestrained. Further observation showed the storage rack was full. Observation on 1/31/12 at 8:11 AM showed resident room #4 had five "B" size oxygen cylinders standing upright and unrestrained. Further observation showed the storage rack was full. At the time of each observation the maintenance director reported he was aware oxygen cylinders were required to be restrained. He further reported the resident in each room was temporarily in the hospital and the oxygen supplier delivered more cylinders than the storage racks could hold. Reference, NFPA 99, 1999 Edition; 4-3.5.2.1 (b) 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.	SALF	(E) 1. **Corrective Action:** Free standing cylinders will be properly chained or supported in a proper cylinder stand or cart. 2. **Systemic Change:** An in-service has been set up for 3/7/12 at our staff meeting for the Director of Maintenance to review the code to ensure compliance. 3. **Monitoring:** The Director of Maintenance will inspect resident rooms where oxygen is in use to ensure all tanks are stored or restrained properly and placed on the monthly check list to ensure compliance. 4. **Date of Completion:** March 30, 2012	

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SALF	Continued From page 5 Wyoming Department of Health, Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4 Section 6. Furnishings, Building, Physical Plant. (i) All drapery and curtains shall be flame retardant. This regulation was NOT MET as evidence by: F. Based on observation and staff interview, the facility failed to ensure curtains were flame retardant in 2 of 3 smoke compartments. The findings were: Random observation throughout the survey on 1/30-31/12 showed the window curtains in resident room #28, #31, and #9 did not have flame retardant documentation attached to them. On 1/30/12 at 4:20 AM the maintenance director reported he was aware of the requirement. He further reported the above mentioned curtains did not have flame retardant documentation or flame retardant solvent applied to them. 32.7.5* Furnishings, Bedding, and Decorations. 32.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in	SALF	(F) **1. Corrective Action:** As required by the applicable code, window curtains shall be flame resistant with required documentation attached. 2,.**Systemic Change:** a) An in-service has been set up on 3/7/12 at our staff meeting to review the code by the Director of Maintenance. b) During the admissions procedure the facility representative will review the code requiring responsible party's signature. 3. **Monitoring:** The Director of Maintenance shall inspect rooms with window curtains quarterly and place on the quarterly checklist to ensure compliance. 4. **Date of Compliance:** March 30, 2012	