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 _____	02/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS CORP DBA/EMERITUS AT ABSARC	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 February 25-26, 2013 by the office of Healthcare Licensing and Surveys, (HLS).

The facility was a fully sprinklered, single-story 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.

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 corridor doors were smoke

Chapter 4, Section 10

Life Safety and Electric Safety (ii)

A. **1. Corrective Action:** All corridor doors will be held in an open position by one means of release.

2. a. Systematic Change: The MD/Designee will conduct an in-service with staff educating them regarding one means of release door closure.

b. A latch or other fastening device will be provided with not more than one releasing device where required.

3. Monitoring: The MD/Designee will monitor quarterly to ensure compliance.

4. Date of Completion: April 15, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Kathleen Schultz — (X6) DATE: 4-1-13

STATE FORM 6899 U6O811 If continuation sheet 1 of 7

POC MODIFIED & ACCEPTED W/ KATHLEEN SCHULTZ, E.D., ON 4/1/13

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SALF	LIC REGS FOR ASSISTED LIVING FACILITIES A Life Safety Code survey was conducted at your facility on February 25-26, 2013 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a fully sprinklered, single-story 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. 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 corridor doors were smoke	SALF	Chapter 4, Section 10 Life Safety and Electric Safety (ii) **A. 1. Corrective Action:** All corridor doors will be held in an open position by one means of release. **2. a. Systematic Change:** The MD/Designee will conduct an in-service with staff educating them regarding one means of release door closure. **b.** A latch or other fastening device will be provided with not more than one releasing device where required. **3. Monitoring:** The MD/Designee will monitor quarterly to ensure compliance. **4. Date of Completion:** April 15, 2013	

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SALF	Continued From page 1 resistant in 1 of 3 smoke compartments. The findings were: Observation on 2/25/13 between 4:30 PM and 5 PM showed the corridor door to the beauty shop and resident room #29 were impeded from closing by wedges. On 2/25/13 at 4:36 PM the maintenance director reported he was unaware corridor doors were prohibited from being held in the open position by any means that required more than one means of release. Reference NFPA 101, 2000 Edition, 32.3.2.1; 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions ... Doors shall be operable with not more than one releasing operation. B. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 2 of 3 smoke compartments. The findings were: 1. Observation on 2/25/13 between 5 PM and 6 PM showed the corridor doors for the sprinkler riser room, medication room, and hot water heater room were unable to be fully latched into the door frames with the force from the self-closing devices, with three attempts each. On 2/25/13 at 5:15 PM the maintenance director could not explain why the aforementioned doors had not been noticed and repaired during the quarterly safety inspections. 2. Observation of the hot water heater room on 2/25/13 at 5:49 PM showed four unsealed pipe penetrations. The largest gap measured 1 ½ inches across. At the time of the observation the	SALF	**B1.1. Corrective Action:** Corridor doors for the sprinkler riser room, medication room, and hot water heater room will be able to fully latch into door frame with the force from the self-closing devices. **2. Systematic Change:** The MD/Designee will repair door/door frame to ensure proper closure. **3. Monitoring:** The MD/Designee will perform bi SEMI annual inspections to ensure proper closure. **4. Date of Completion:** April 15, 2013 **B2.1. Corrective Action:** In the hot water heater room, the four unsealed pipes will be sealed. **2. System Change:** The MD/designee will seal the gaps around unsealed pipes. **3. Monitoring:** The MD/Designee will seal the gaps around the unsealed pipes. REVIEW ANNUALLY **4. Date of Completion:** April 15, 2013	

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SALF	Continued From page 2 maintenance director could not explain why the penetrations had not been noticed and repaired during the quarterly safety inspections. Reference NFPA 101, 2000 Edition; 32.3.3.2.2 Every hazardous area shall be separated from other parts of the building by a smoke partition in accordance with 8.2.4. Hazardous areas shall include, but shall not be limited to the following: (1) Boiler and heater rooms (2) Laundries (3) Repair shops (4) Rooms or spaces used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. C. Based on record review and staff interview, the facility failed to ensure emergency battery lights were tested on an annual basis in 3 of 3 smoke compartments. The findings were: Review of the emergency battery light testing records showed the facility did not have record of the last 90 minute annual test. On 2/26/13 at 9 AM the maintenance director confirmed there were no other records to review. He could not explain why the previous maintenance director had not maintained the emergency battery light test records. Reference NFPA 101, 2000 Edition, 32.3.2.9; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An	SALF	**C.1. Corrective Action:** Emergency battery lighting system will be tested and documented on an annual basis ensuring the 90 minute annual test is accomplished. **2. Systematic Changes:** The MD/Designee will test and document using a new reporting test document to ensure compliance. **3. Monitoring:** The MD/Designee will conduct, test and document on an annual bases. **4. Date of Completion**: March 10, 2013	

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SALF	Continued From page 3 annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1-1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. D. Based on record review and staff interview, the facility failed to ensure 1 of 7 fire alarm system components was tested. The findings were: Review of the fire alarm system testing records showed the receiver was not tested during the month of June 2012. On 2/26/13 at 9 AM the maintenance director reported the receiver was tested during fire drills. A fire drill was not conducted during June 2012 and so the receiver was not tested. Reference NFPA 101, 2000 Edition, 32.3.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 23. Receivers,.....monthly E. Based on record review and staff interview, the facility failed to ensure the kitchen hood exhaust system was cleaned on a semi-annual basis. The findings were: Review of the kitchen hood testing records showed the exhaust system was last tested on 6/3/2011. On 2/26/13 at 9 AM the maintenance director reported he was unaware the system was required to be cleaned on a semi-annual basis. At 10 AM the executive director reported she was also unaware the exhaust system was required to be tested semi-annually. Reference NFPA 101, 2000 Edition, 32.3.6.2.1,	SALF	**D.1. Correction Action:** Fire alarm system records reflecting the test of the receiver will be conducted and documented monthly. **2. Systematic Change:** The MD/Designee will conduct and document the test of the receiver as evidence during monthly fire drills. **3. Monitoring:** The MD/Designee will conduct and document on a monthly basis. **4. Date of Completion:** ~~Monthly~~ 2/28/13 **E.1. Corrective Action:** The facility will ensure and have documentation ensuring the kitchen hood exhaust system has been cleaned and tested semi-annually. **2. Systematic Change:** The MD/DSD will place in the Preventive Maintenance Program the ~~bi~~-annual SEMI- inspection/cleaning of the kitchen exhaust system. **3. Monitoring:** The MD/DSD will document and check inspection compliance ~~bi~~-annually. SEMI- **4. Date of Completion:** February 28, 2013	

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SALF	Continued From page 4 9.2.3, NFPA 96, 1998 Edition; 8-2* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire- actuated water system shall be made at least every 6 months by properly trained and qualified persons. 8-3 Cleaning 8-3.1 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. After the exhaust system is cleaned to bare metal, it shall not be coated with powder of other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person (s) acceptable to the authority having jurisdiction in accordance with Table 8-3.1 Table 8-3.1 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 8-3.1.1 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 in accordance with Section 8-3. --- Wyoming Department of Health Aging Division Rules Program Administration of Assisted Living Facilities Chapter 12	SALF		

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SALF	Continued From page 5 Effective December 12, 2007 Section 7. Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency Procedures, and Fire Safety. (i) Evacuation Capability. (A) The evacuation capability rating for the group of residents, as defined by the Life Safety Code, in accordance with licensure rules, shall meet prompt or slow for facilities with nine (9) or more residents, and the rating shall meet prompt for facilities of eight (8) or fewer residents. The facility shall be responsible for maintaining evacuation capability ratings by timed fire exit drills. (I) Exception shall be a facility where the construction meets the impractical evacuation capability rating. (B) Evacuation Capability Ratings: (I) Prompt - maximum of three (3) minutes (II) Slow - between three (3) and thirteen (13) minutes (III) Impractical - more than thirteen (13) minutes (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	SALF		

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SALF	Continued From page 6 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 evidence by: --- F. Based on record review and staff interview, the facility failed to ensure fire drills were held on a quarterly basis on 1 of 3 shifts. The findings were: Review of the fire drill records showed the third shift occurred between 11 PM and 7 AM. Further review showed a fire drill had not been conducted during the second quarter of 2012 on the third shift. On 2/26/13 at 9 AM the maintenance director could not explain why the pervious maintenance director had not performed a fire drill at the aforementioned time.	SALF	**F.1. Corrective Action:** Fire drills will be held on a quarterly basis per the evacuation capacity guidelines in the Wyoming Life Safety Code Operating Features. Both minutes and seconds will be recorded. **2. Systematic Change:** The MD/Designee will be responsible for conducting and recording fire drills monthly, to include minutes and seconds of the requesting drills. **3. Monitoring:** The MD/Designee will conduct and document monthly evacuation drills. **4. Date of Completion**: April 15, 2013	