STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING _____ B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 Life Safety Code survey was conducted at your facility on February 5, 2013 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a two-story, fully sprinkled building of Type V (111) construction built in 1998 and 2012. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 94 licensed beds, 73 beds were Level I and 21 beds were Level II. The facility had a census of 50 Level I and 11 Level II 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, 1994 and 2006 Editions and New Health Care 2006 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: _____	SALF	**A.)** The maintenance director will loosen a screw in the self closing mechanism of the door. We will check all doors in the facility that are supposed to be self closing to ensure each door is in compliance. We will put each door an a quarterly check for proper closing in regards to self closing This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team. This will be completed by 4/20/2012 ~~4/20/2012~~ 4/6/13 **B.)** The maintenance director filled the 1 inch square wall penetration on 2/15/2013 The maintenance director will thoroughly check the entire building to ensure no other penetrations exist. We will have walls put on a quarterly check to ensure wall penetrations do not exist, and if they do that they are properly filled.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

David J. Lovato Regional VP 2/25/13

Proc. Modified & Approved w/ David J. Lovato, Regional V.P., on 3/4/13

Healthcare Licensing and Surveys

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SALF	Continued From page 1 A. Based on observation and staff interview, the facility failed to ensure 1 of 4 fire barrier double doors were smoke resistant. The findings were: Observation of the fire barrier near resident room #212 on 2/5/13 at 12:53 PM showed one of the two doors was not able to fully latch into the door frame with the power of the self-closing device. At the time of the observation the environmental services director reported the fire barrier doors were not routinely inspected to ensure they were smoke resistant. Reference NFPA 101, 2006 Edition New Board and Care, 32.3.3.7.5; 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, Listed, labeled fire doors assemblies are fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with NFPA 80 .... B. Based on observation and staff interview, the facility failed to ensure walls were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of the resident services office on 2/5/13 at 10:55 AM showed there was a 1 inch square wall penetration. At the time of the observation the environmental services director could not explain why the hole had not been noticed and repaired during the quarterly safety inspections. Reference NFPA 101, 1994 Edition New Board and Care; 22-3.1.3.1 Construction requirements for large	SALF	This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team. This was completed by 2/15/2013 **C.)** The double doors in the Wyoming Cowboy Television Room will have a device installed by the environmental services director to ensure they do not have a gap greater than 1/8 inch. All doors in the facility will be checked and measured to ensure a gap no greater than 1/8 inch. All doors will be checked quarterly to ensure proper distance between doors. This will be monitored by the environmental services director and checked quarterly by the quality assurance team for compliance. This will be completed by 4/20/2012 4/6/13 **D.)** **1.)** The pressure clip will be removed from the door on the dishwashing room that is connected to the kitchen by the	2/15/2013 ~~4/20/2012~~

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SALF	Continued From page 2 facilities shall be as required by this section. Where noted as fully sheathed, the interior shall be covered with a lath and plaster or material providing a 15-minute thermal barrier. C. Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of the Wyoming Cowboy television room on 2/5/13 at 2:06 PM showed the gap between the double doors was greater than 1/8 inch wide. The gap measured ¼ inch between the two doors. At the time of the observation the environmental services director reported the corridor doors were not routinely inspected to ensure they were smoke resistant. Reference NFPA 101, 2006 Edition New Board and Care; 32.3.3.6.4 Doors protecting corridor openings shall not be required to have a fire protection rating, but shall be constructed to resist the passage of smoke. D. Based on observation and staff interview, the facility failed to ensure hazardous areas were smoke resistant in 2 of 9 smoke compartments. The findings were: 1. Observation of the dish washing room on 2/5/13 at 12:05 PM showed it was connected to the kitchen. Further observation showed the dish room door was equipped with a self-closing device, the door was held in the open position with a pressure clip that was not able to release with the activation of the fire alarm system. At the time of the observation the environmental services director reported he was unaware	SALF	environmental services director and this topic will be discussed with the dietary services manager as well to ensure this type of device is not used in the future. All doors in the facility will be checked to ensure that a pressure clip is not being used, and that only door holding devices that release in accordance to the fire alarm system are being used. All doors will be checked quarterly in regards to this topic to ensure compliance. This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team. This will be completed by 4/20/2012 ~~4/20/2012~~ 4/6/12 **2.)** The maintenance director has adjusted the latch to ensure that this door fully latches on its own. We will check all doors in the facilities that are supposed to be self closing to ensure each door is in compliance. We will put each door an a quarterly check for proper closing in regards to self closing This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team.	

Healthcare Licensing and Surveys

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SALF	Continued From page 3 hazardous area doors were only allowed to be held open with devices that released with the activation of the fire alarm system. 2. Observation of the second floor laundry room on 2/5/13 at 2:11 PM showed the self-closing device was not able to fully latch the door into the door frame, with three attempts. Reference NFPA 101, 1994 Edition New Board and Care; 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 by either: 1. An enclosure with a fire resistance rating of at least 1 hour ... 2. Automatic sprinkler protection, in accordance with 22-2.3.5, of 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 door in such separation shall be self-closing or automatic-closing in accordance with 5-2.1.8. E. Based on observation and staff interview, the facility failed to ensure corridor doors were unobstructed and failed to ensure delayed egress doors were signed in 4 of 9 smoke compartments. The findings were: 1. Observation of resident room #202 on 2/5/13 at 11:31 AM showed an accordion gate was attached to the door frame. At the time of the observation the environmental services director reported he was unaware accordion doors were only allowed if they were not attached to the door frame.	SALF	This was completed by 2/15/2013 **E.)** **1.)** The environmental services director will remove the accordion gate that is attached to the door frame. The environmental services director will check the entire facility to ensure that accordion gates are not being used when attached to door frames. This will be checked quarterly for compliance by the environmental services director. This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team. This will be completed by 3/15/2013 **2.)** The environmental services director has installed signs that read; PUSH UNTIL ALARM SOUNDS, DOORS CAN BE OPENED IN 15 SECONDS on the two north exit doors and the south exit door.	2/15/2013 3/15/2013

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SALF	Continued From page 4 2. Observation of the egress system on 2/5/13 between 1 PM and 2:30 PM showed the delayed egress locks on the two north exit doors and south exit in the new building were not provided with instruction signs. At the time of the observation the environmental services director reported he was unaware a sign stating, PUSH UNTIL ALARM SOUNDS, DOORS CAN BE OPENED IN 15 SECONDS, was required on all doors equipped with delayed egress locks. Reference NFPA 101, 2006 Edition New Board and Care; 32.3.2.2.2 Doors. Doors in means of egress shall be as follows: (4) Delayed-egress locks in accordance with 7.2.1.6.1 shall be permitted, provided that not more than one device is located in an egress path ... 7.2.1.6.1 Delayed-Egress Locks. Approved, listed delayed-egress locks shall be permitted to be installed on doors serving low or ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system ... (5) A readily visible, durable sign in letter not less than 1 in. high and not less than 1/8 in. in stroke width on a contrasting background that reads as follows shall be located on the door adjacent to the release device: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS F. Based on observation, record review and staff interview, the facility failed to ensure battery lights were functional in 1 of 9 smoke compartments and failed to ensure 2 of 2 emergency battery light tests were performed. The findings were:	SALF	The environmental services director will check the facility to ensure all exit doors have the correct signage. This will be checked quarterly by the environmental services director. This will be monitored quarterly for compliance by the environmental services director, the executive director, and the quality assurance team. This was completed by 2/15/2013 **F.)** **1.)** The environmental services director will replace the battery in the emergency light near resident room # 213. The environmental services director will check all of these lights throughout the facility to ensure they are working properly and have a working battery. These lights will be tested monthly by the environmental services director. This will be monitored monthly by the environmental services director, the executive director and the quality assurance team to ensure compliance with thee tests. ~~This will be completed by 4/20/2012~~	2/15/2013 ~~4/20/2012~~ 4/6/13

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SALF	Continued From page 5 1. Observation of the corridor emergency battery light near resident room #213 on 2/5/13 at 2:57 PM showed the light would not illuminate when the test button was depressed. At the time of the observation the environmental services director could not explain why the battery light was not replaced during the monthly test. 2. Review of the emergency battery light testing records showed the lights were tested on 11/15/12, 9/25/12 and 1/7/12 in the past year. Further review showed the facility did not have a record of the last 90 minute annual test performed. On 2/5/13 at 2:56 PM the environmental services director could not explain why the last director had not completed the aforementioned tests. Reference NFPA 101, 2006 Edition New Board and Care, 32.3.2.9; 7.9.3 Periodic Testing of Emergency Lighting Equipment. 7.9.3.1.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted at 30-day intervals for not less than 30 seconds. (2) Functional testing shall be conducted annually for not less than 1 1/2 hours if the emergency lighting system is battery powered. (3) The emergency lighting equipment shall be fully operational for the duration of the tests by 7.9.3.1.1 (1) and (2). (4) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. G. Based on observation and staff interview, the facility failed to ensure exterior doors that did not lead to a public way were signed with NO EXIT	SALF	2.) The environmental services director will check all lights to ensure compliance. The environmental services director will also perform an annual 90 minute test. The EVS director will check all lights in the facility. The environmental services director will check these lights monthly in addition to the annual 90 minute test. This will be monitored quarterly for compliance by the quality assurance team. This will be completed by 4/20/2012 G.) The environmental services director will order and place a NO EXIT sign on the memory care unit courtyard door. The EVS director will also check all doors that require this signage and ensure that they are in place. This will be checked quarterly by the EVS director. This will be monitored quarterly for compliance by the EVS director, the executive director, and the quality assurance team.	~~4/20/2012~~ 4/6/13

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SALF	Continued From page 6 signs in 2 of 9 smoke compartments. The findings were: Observation of the memory care unit courtyard door on 2/5/13 at 11:42 AM showed the door was not posted with a NO EXIT sign. Further observation showed the courtyard door near resident room #202 was not posted with a NO EXIT sign. At the time of the observation the environmental services director reported he was unaware exterior doors that did not lead to a public way were required to be signed with a NO EXIT sign. Reference NFPA 101, 2006 Edition New Health Care, 18.2.10.1, 7.10.8.3* No Exit. 7.10.8.3.1 Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT 7.10.8.3.2 The NO EXIT sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO, unless such sign is an approved existing sign. H. Based on observation and staff interview, the facility failed to ensure 8 of 8 fire alarm system components were tested in the past year. The findings were: Review of the fire alarm system testing records showed the facility did not have a record of the system being tested within the last year. On 2/5/13 at 5 PM the executive director could not	SALF	This will be completed by 4/20/2012 **H.)** The environmental services director has contacted a contractor to test the fire alarm system to have the annual fire alarm system testing completed The environmental services director will have this test scheduled annually to ensure compliance. This will be monitored by the EVS director, executive director, and the quality assurance team annually for compliance. This will be completed by 2/28/2013 **I.** **1.)** The environmental services director will have the contractor replace the sprinkler heads in the resident services office and #101 restroom on 2/28/2013 to ensure they are not covered with a foreign substance. All sprinkler heads will be checked in the facility by the EVS director to ensure none of the heads are covered with a foreign substance.	~~4/20/2012~~ 4/6/13 2/28/2013

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SALF	Continued From page 7 explain why the fire alarm system was not tested on an annual basis. Reference NFPA 101, 2006 Edition New Board and Care, 32.3.3.4.1, 9.6.1.3, NFPA 72 2002 Edition; 10.6.2 Maintenance, Inspection, and Testing Records. 10.6.2.1 Records shall be retained until the next test and for 1 year thereafter. 10.6.2.3 A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 10.6.2.3: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested, for example, (8) Functional test of detectors (9) Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturer ' s published instructions (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15) Disposition of problems identified during test	SALF	The EVS director will check all heads quarterly to ensure they are clear from foreign substances and ensure compliance. This will be monitored quarterly for compliance by the EVS director, the executive director and the quality assurance team. This will be completed by 2/28/2013 **2.)** The eight sprinkler heads in the chapel will be replaced with 150 degree sprinkler heads by the contractor on the 28th of February. All heads temperature rating will be checked in the facility to ensure the proper rated heads are in the correct places This will be checked annually or upon any change in regulation by the EVS director. This will be monitored by the EVS director, the executive director, and the quality assurance team annually or upon change in regulation to ensure compliance. This will be completed by 2/28/2013 3.)	2/28/2013 2/28/2013

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SALF	Continued From page 8 (e.g., owner notified, problem corrected/successfully retested, device abandoned in place) I. Based on observation and staff interview, the facility failed to ensure sprinklers were not covered with foreign material in 3 of 9 smoke compartments, failed to ensure sprinkler heads were installed for the proper temperature rating in 1 of 9 smoke compartments, and failed to provide two spare sprinkler heads for each type installed. The findings were: 1. Observation of the sprinkler system on 2/5/13 between 10:30 AM and 12 PM showed the sprinkler heads in the resident services office and #101 restroom, were covered with dry wall texture. On 2/5/13 at 10:54 AM the environmental services director could not explain why the sprinkler contractor had not noticed and replaced the aforementioned heads during there last annual inspection. 2. Observation of the chapel on 2/5/13 at 1:06 PM showed the eight installed sprinkler heads were not 150 degree, ordinary temperature heads, they were 200 degree, high temperature heads. Review of the 11/15/12 inspection report showed the sprinkler contactor had noted the heads needed to be replaced with 150 degree ordinary temperature heads. Review also showed this same comment was noted on every quarterly inspection since the 5/8/12 inspection. On 2/5/13 at 5 PM the executive director could not explain why these heads had not been replaced. 3. Observation of the spare sprinkler cabinet on 2/5/13 at 1:14 PM showed there were no 200 degree pendent heads to replace the heads installed in the riser room. Further observation	SALF	The EVS director will order and have in place the proper spare heads and a sprinkler wrenches for the attic sprinkler heads and the TYCO pendant sprinkler heads. These will be kept in the spare sprinkler cabinet. The EVS director will check storage to ensure we have the proper replacement materials and tools on hand to complete any needed work. The EVS director will check this cabinet monthly to ensure the proper materials are on hand. This will be monitored quarterly by the executive director and the quality assurance team. This will be completed by 4/20/2013 J.) The EVS director will inspect the extinguisher near the main entrance The EVS director will inspect the extinguisher in the memory care southeast storeroom. The EVS director will inspect the extinguisher in the memory care mechanical room The EVS director will inspect the extinguisher in the elevator equipment room.	~~4/20/2013~~ 4/6/13

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SALF	Continued From page 9 showed there was not a sprinkler wrench for the attic sprinkler heads or the TYCO pendent sprinkler heads. Review of the 5/8/12 quarterly inspection report showed the sprinkler contactor had noted the lack of heads and wrenches. Review also showed this same comment was noted on every quarterly inspection since the 5/8/12 inspection. On 2/5/13 at 5 PM the executive director could not explain why these heads and wrenches had not been supplied. Reference NFPA 101, 2006 Edition New Board and Care, 32.3.3.5.1, 9.7.1.1, NFPA 25 2002 Edition; 5.4.1.4 A supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated of been damaged in any way can be promptly replaced. 5.4.1.5 The stock of Spare Sprinklers shall include all types and ratings installed and shall be as follows: (a) ...Under 300 sprinklers - no fewer than 6 sprinklers (b) ...300 to 1000 sprinklers - no fewer than 12 sprinklers (c) ...Over 1000 sprinklers - no fewer than 24 sprinklers 5.4.1.6 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. 5.4.1.8 Sprinklers shall not be altered in any respect or have any type of ornamentation, paint, or coating applied after shipment from the place of manufacture. J. Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 3 of 9	SALF	The EVS director will also inspect all the extinguishers in the facility to ensure they are inspected and up to date with compliance. The EVS director will check all extinguishers monthly and have recorded documentation of this. This will be monitored monthly by the EVS director and the executive director and quarterly by the QA team for continued compliance. 4/6/13 K.) a.) The EVS director will remove the three way adaptor and have it plugged into a compliant power strip, ROOM # 208. The EVS director will check all outlets in the facility to ensure items are lugged into the proper and safe type of power strip. The EVS director and housekeeping staff will check all outlets monthly to ensure items are not improperly being plugged in to the wrong type of adaptor. This will be monitored quarterly by the executive director, the EVS director, and the quality assurance team. This will be complete by 3/15/2013	3/15/2013

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SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

3/4/13

(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	Continued From page 10 smoke compartments. The findings were: Observation on 2/5/13 between 10:30 AM and 1:30 PM showed the following portable fire extinguishers were not inspected on a monthly basis: a. The extinguisher near the main entrance was not inspected 11/2012. b. The extinguisher in the memory care southeast storeroom was not inspected 11-12/2012. c. The extinguisher in the memory care mechanical room was not inspected 10-11-12/2012. d. The extinguisher in the elevator equipment room was not inspected 4-5-6-7-8-9-10-12/2012. On 2/5/13 at 10:56 AM the environmental services director could not explain why the previous director had not inspected the aforementioned extinguishers. Reference NFPA 101, 1994 Edition New Board and Care, 32.3.3.5.6, 9.7.4.1, NFPA 10, 2002 Edition; 6.2 Inspection. 6.2.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals .... K. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace fixed permanent wiring in 2 of 9 smoke compartments. The findings were: Observation of the electrical system on 2/5/13 between 10 AM and 11:30 AM showed the following locations had temporary electrical adapters replacing fixed permanent wiring: a. The computer in resident room #208 was plugged into a 3-way adapter.	SALF	**b.)** The EVS director will remove the two surge protectors in line and have the computer in the clinical services office properly plugged into the correct surge protector. The EVS director will check all outlets in the facility to ensure items are lugged into the proper and safe type of power strip. The EVS director will check all outlets quarterly to ensure items are not improperly being plugged in to the wrong type of adaptor. This will be monitored quarterly by the executive director, the EVS director, and the quality assurance team. This will be complete by 3/15/2013 **L.)** The EVS director and executive director will properly train and in-service all staff and residents on the proper protocol of a fire drills. This will include education on a full evacuation and the state requirements. The EVS director and executive director will have continued education with current and new staff and residents to	3/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING _____ B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

3/4/13

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SALF	Continued From page 11 b. The computer in the clinical services office was plugged into two surge protectors in-line. On 2/5/13 at 11:12 AM the environmental service director could not explain why the aforementioned adapters had not been noticed and removed during the quarterly safety inspections. Reference NFPA 101, 2006 Edition New Board and Care, 32.3.6.1, 9.1.2, NFPA 70, 2005 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 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.	SALF	ensure continued education, and so that all staff are knowledgeable of fire drill requirements. The EVS director and executive director will present this quarterly or upon new hire and move in to ensure continued compliance. This will be monitored quarterly by the EVS director, executive director, and the quality assurance team for compliance. This will be completed and in place by 4/20/2013	~~4/20/2013~~ 4/6/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING _____ B. WING _____	02/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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SALF	Continued From page 12 (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 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	SALF		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF014	A. BUILDING _____ B. WING _____	02/05/2013

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SALF	Continued From page 13 the form. This regulation was NOT MET as evidence by: --- L. Based on record review and staff interview, the facility failed to ensure residents evacuated during fire drills in 9 of 9 smoke compartments. The findings were: Observation of the fire drill on 2/5/13 at 4:25 PM showed residents stopped at exit doors and did not evacuate. Staff members called over the two-way radios that halls were cleared once the residents reached the exit doors without actually leaving the building. The residents in the 200 and 300 halls stopped at the exit doors and had to be coached to evacuate. On 2/5/13 at 4:40 PM the executive director could not explain why staff members called halls all clear with residents stopped at exit doors. She also could not explain why residents were unfamiliar with exiting the building when the fire drill records indicated full evacuation occurred with each fire drill in the past year.	SALF		