Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF019	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNDANCE ASSISTED CARE	108 ABBY LANE SUNDANCE, WY 82729

(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 An annual Health and Life Safety Code survey was conducted at your facility by the Office of Healthcare Licensing and Surveys (HLS) on 02/13-14/13. The survey revealed the facility was out of compliance with the Rules and Regulations for Licensure (Chapter 4) and for Program Administration (Chapter 12) of Assisted Living Facilities (ALF). The facility was a single-story, fully sprinkled building of Type II (111) construction built in 2001. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 15 licensed beds and a census of 14. Chapter 4. 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 evidenced by: 1. Based on observation, record review and staff interview, the facility failed to ensure the fire alarm system was fully operational. The findings were:	SALF		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: owner/Administrator | (X6) DATE: 3-4-13

Revised/approved c changes on pgs 3, 4, 5, 7 per PC c Manager on 3/21/13 at 2:48

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SALF	Continued From page 1 a. Record review on 2/13/13 at 1:48 PM revealed the annual inspection of the fire alarm system was not done in 2012. The last annual inspection was conducted by Collins Communications from Gillette on 12/16/11. b. Observation on 2/13/13 at 9:48 AM revealed 2 of the 15 fire alarm strobe lights had duct tape attached to them. The strobes were located in the hallway on each side of the dining room. c. Interview with the facility owner at that time confirmed the 2012 annual inspection was not done. The owner also stated the tape on the strobes was most likely left there after the wall was painted. Reference: NFPA 101 Life Safety Code, 1994 Edition 22-3.3.4.1 General. A fire alarm system in accordance with Section 7-6 shall be provided. 7-6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. 2. Based on observation, facility documentation and staff interview, the facility failed to provide an electrical system installed in accordance with NFPA 70. The findings were: Observation on 2/13/13 between 11:48 AM and 2:01 PM revealed the following findings: a. Two electrical panels (panels "A" and "B") were blocked in the mechanical room by a box of kitchen supplies, a wheelchair and a propane lamp. In addition, a poster was attached to the panel "A" which stated "circuit panels must	SALF	**1 a. The survey and corrective actions will be posted for all residents and employees to review. Contractor has scheduled an inspection for 3-13-13. The Contractor has now placed the inspection on their annual inspection schedule** **The Manager will review the safety manual quarterly to ensure compliance with the regulations. This plan will be added to the Policy and Procedure Manual** **The Fire alarm system is a modern "Simplex 4010" system that self checks itself every second and did not observe any failures to the system. There was no risk to residents or employees** **b. The owners were not present for the inspection** **Two of four strobe lights were covered to prevent seizure to people that might see more than one strobe at a time per request of the state Fire Marshall inspection they will remain covered. There are still two strobes in the rooms observed.** **The architect had too many strobes installed during construction.**	03/13/13

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SALF	Continued From page 2 have 3 feet of working space. please do not block". b. An unprotected electrical splitter was observed in resident room 105. Plugged into the splitter were the resident's TV and an electrical light. c. Interview with the facility owner at the time of the observations confirmed the findings. Reference NFPA 101 Life Safety Code, 1988 Edition, Chapter 32 Referenced Publications. Reference: NFPA 70, National Electrical Code, 1999 Edition. Article 110-26. Spaces about electrical equipment. Sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. (a) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of (1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of access to live parts shall not be less than indicated in table 110-26(a). Table 110-26(a) Nominal Voltage Minimum Clear Distance to Ground (0/150 volts) 3 ft. (b) Clear Space. Working space required by this section shall not be used for storage. 3. Based on observations and staff interview the facility failed to maintain the fully sheathed surfaces of the building in 2 of 4 smoke compartments. The findings were: Observation on 2/13/13 between 11:48 AM and	SALF	**2 a The survey and corrective actions will be posted for all residents and employees to review. Checks will be added to housekeeping duty list to have written follow up to the inspection. Manager will review the safety manual quarterly to ensure compliance with the regulations. Staff will be informed of responsibilities to comply with the standard 3 feet of working space.** **2 b The survey and corrective actions will be posted for all residents and employees to review. The splitter was replaced during this inspection with a surge protection strip on 2-12-13.** **Power strips will be required to be approved by the facility. Staff will be informed of responsibilities to comply with the standard.**	02/14/13

#2 Report findings to QA Committee

#1 The manager will conduct quarterly inspections & report findings to the QA Meeting

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SALF	Continued From page 3 2:01 PM revealed the following findings: a. A square 6" x 6" hole was observed in the wall of the hallway by the public restroom. b. A gap was observed around a metal rod protruding through the ceiling drywall in the mechanical room. The rod was used as a hanging support rod for the sprinkler system water pipe. c. Interview with the facility owner at the time of the observations confirmed the findings. The owner stated the 6 inch hole had to be cut out of the wall in order to gain access to the water pipes and the hole was not fixed. Reference NFPA 101 Life Safety Code, 1994 Edition: 22-3.1.3.1 Construction requirements for large facilities shall be as required by this section. Where noted as "fully sheathed", the interior shall be covered with a lath and plaster or materials providing a 15-minute thermal barrier. 4. Based on observations and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13. The findings were: Observations on 2/13/13 at 12:12 PM revealed the sprinkler heads and escutcheons in resident rooms 110 and 111 had separated from the ceiling leaving a one inch gap. Interview with the facility owner at the time of the observations confirmed the findings. 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....	SALF	**3 a The survey and corrective actions will be posted for all residents and employees to review.** **A contractor is scheduled to correct 6"x6" hole on 3-9-13.** **The Manager will follow up to ensure compliance.** (#1) **3 b The survey and corrective actions will be posted for all residents and employees to review.** **Contractor is scheduled to correct the gap on 3-9-13.** **The Manager will follow up to ensure compliance.** (#1) **4 The survey and corrective actions will be posted for all residents and employees to review.** **Contractor is scheduled to correct the sprinkler head and escutcheons issues in room 110 and room 111 on 3-9-13.** **The Manager will follow up to ensure compliance.** and report findings to the QA committee	

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SALF	Continued From page 4 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. 5. Based on observation and staff interview, the facility failed to ensure two hazardous areas were separated from the patient use area in one of 1 of 3 smoke compartments. The findings were: Observation on 2/13/13 at 2:48 PM revealed the door to the laundry room was held open with a wedge placed under the door. The door did have a self closure device attached to it. In addition, the door to the kitchen labeled "employee door" also had a SCD attached to it. However, the door did not close after three attempts. Interview with the facility owner at the time of the observation confirmed the findings. Reference NFPA 101 Life Safety Code, 1994 Edition: 22.2.3.2 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: (2) Automatic sprinkler protection, in accordance with 22.2.3.5 of a hazardous area and a separation that will resist the passage of smoke between the hazardous area and the sleeping area of primary escape route. Any doors in such separation shall be self-closing or automatic-closing in accordance with 5-2.1.8.	SALF	**5 The survey and corrective actions will be posted for all residents and employees to review.** **Employee meetings will be held to ensure compliance of the regulation.** **Manager follow up will be done quarterly and an inspection task will be added to the housekeepers check list.** **The door to the kitchen labeled "employee door" was adjusted to close and does not latch. A new latch will be ordered and installed to comply with the regulation.**	

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SALF	Continued From page 5 6. Based on record review and staff interview, the facility failed to conduct an annual 90 minute emergency lights testing. The findings were: Record review on 2/13/13 at 3:48 PM revealed no documentation was available to indicate that the 90 minute annual testing of emergency lights (battery backup) had been conducted or recorded for 2012. Interview with the facility staff responsible for the testing stated she was not aware of the annual testing requirement. She also confirmed the facility did not have a generator for emergency power backup but rather did have battery backup for the emergency exit lights. Reference NFPA 101 Life Safety Code, 1994 edition: 31-1.3.7: A functional test shall be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test shall be conducted for the one and one-half hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual testing and tests shall be kept by the owner for inspection by the authority having jurisdiction. Chapter 12, Section 7: Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency Procedures, and Fire Safety (iii) Fire safety (C) Clearly readable floor diagrams reflecting the actual floor arrangement showing the exit locations and evacuation routes shall be posted in conspicuous places. This REGULATION was not met as evidenced by:	SALF	**6 The survey and corrective actions will be posted for all residents and employees to review.** **The 90 minute annual testing of emergency lights is in the process of checking no less than 10 Battery backup lights and should be completed by 3-9-13. Results from these testing will be recorded in the fire log book.** **Employee meetings will be held to ensure compliance of the regulation.** **Manager follow up will be done annually.**	

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SALF	Continued From page 6 7. Based on observation and staff interview, the facility failed to post an accurate emergency exit floor plan. The findings were: Observation on 2/13/13 at 9:48 AM revealed the emergency exit floor plan posted on the wall in the dining room. The plan indicated one emergency exit: the front entrance. The plan did not indicate the two ends of hall emergency exits. Additional observation at that time revealed at the end of each hall was a clearly marked emergency exit sign and exit doors. Interview with the facility owner at the time of the observation confirmed the plan was incorrect. Chapter 12, Section 7. Assisted Living Facility (ALF) Core Services. (n) 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. This REGULATION was not met as evidenced by: 8. Based on observation and staff interview, the facility failed to secure four portable oxygen tanks in one resident room. The findings were: Observation on 2/13/13 at 11:48 AM revealed four full size "E" unsecured oxygen tanks standing upright on the floor in the living room of resident's room 104. Interview with the administrator at the time of the observation confirmed the finding. Chapter 12, Section 8. Services which cannot be provided by the Level 1 ALF staff.	SALF	**7 The survey and corrective actions will be posted for all residents and employees to review.** **A new floor plan was designed and posted on 3-4-13 to show all exits.** **Additional floor plans were placed out by the commons area of the main dining hall and added to the fire safety book** **Manager follow up will be done annually** **8 The survey and corrective actions will be posted for all residents and employees to review.** **The oxygen tanks were secured on 2-14-13.** **Employee meetings will be held to ensure compliance of the regulation.** **This room was vacant on 2-21-13 and corrective actions have been made.**	03/04/13 02/14/13

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SALF	Continued From page 7 (a) The following services cannot be provided (i) Continuous assistance with transfer and mobility (vii) Incontinence care by facility staff. This REGULATION was not met as evidenced by: 9. Based on observation record review and staff interview, the facility failed to transfer and/or discharge two residents (#1, #2) who exceeded the ability of the facility to provide services. The findings were: Observation on 2/13/13 at 11:30 AM revealed resident #1 sitting in a chair in his/her room. At that time a staff member entered the room and announced it was time for lunch. Observation then revealed the resident was unable to transfer from the chair into a wheelchair (WC) without assistance from the resident's spouse and the staff member. The transfer took over 4 minutes. Staff then pushed the resident to the dining room table. Medical Record Review on 2/13/13 at 3:48 PM revealed: a) The annual (January 2013) ALF102 for resident #1 stated the resident was completely dependant on staff or spouse for mobility. In addition, the 102 also stated the resident required total assist with dressing/grooming and bathing. b) The 12/11/12 care plan stated "Resident ambulates via WC. Progress minimal. Staff needs to assist resident to safety during drills. The resident is exhausting the spouse with toileting needs. Encourage to call staff." c) Nursing notes dated 1/15/13 stated "Resident continues to steadily decline. Uses WC almost exclusively."	SALF	**9. Resident #1 is on a waiting list for a nursing care facility.** **Resident #1 has a spouse that assists but usually calls for assistance. We have recently received an agreement with the family for additional assistance from a home health agency while the family awaits an opening in the above mentioned nursing home. This was already in progress upon the inspection.** **The Manager is in frequent communication with this residents family.**	

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SALF	Continued From page 8 Observation on 2/14/13 at 8:06 AM revealed resident #2 sitting in a chair in his/her room. A strong odor was coming from the resident's room. Interview with CNA #1 at that time revealed the resident experienced incontinence of bowel earlier in the morning. When asked about bowel incontinence, she stated the resident was "mostly incontinent". Medical Record Review on 2/13/13 at 3:48 PM revealed: a) The January 2013 care log recorded the resident was completely incontinent of bladder and was mostly incontinent of bowel for the month. b) Review of the annual ALF revealed the resident stated to the nurse doing the assessment that "I can't tell when I have to go". The interview also stated "the resident ambulates with a wheel walker. Slowly!" c) Review of the 12/4/12 care plan revealed "the resident walks very slowly with a front wheel walker. Resident will require a wheelchair when evacuating the building due to a drill. Staff to assist when evacuating facility." Observation on 2/14/13 at 10:00 AM during a fire drill revealed the resident sitting in a WC and attempting to ambulate down the hallway with minimal success. Progress was extremely slow. A staff member had to assist the resident by pushing him/her down the hall to the exit in order to clear the hallway and allow other residents behind resident #2 to get to the exit. Interview with CNA #1 after the drill revealed the resident returned from the hospital about a week ago and has "experienced a significant decline in ADLs ever since returning."	SALF	**9. Resident #2 had also begun the process of relocation and was discharged to a nursing facility on 2-21-13** **This information was given at the time of inspection.** **The Manager is in contact with the family through this transition process.**	02/21/13