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WY Dept of Health
JUL 18 2013
Healthcare Licensing and Surveys

PRINTED: 07/02/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF003	A. BUILDING _____ B. WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WIND ASSISTED LIVING COMMUNIT	3955 EAST 12TH STREET CASPER, WY 82609

(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 Original Building A Life Safety Code survey was conducted at your facility on June 17-18, 2013 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a single story, fully sprinklered building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 50 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, 1994 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: --- A. Based on observation and staff interview, the facility failed to ensure 2 of 3 fire barrier walls	SALF	**Place your Plan of Correction here.** A.) The environmental services director will fill all holes in the mentioned fire walls. The environmental services director and the administrator will check all fire walls to ensure there are no gaps. We will put each fire wall on a semi annual check to ensure that no penetratable holes are in existence in any fire walls within the community. This will be monitored annually by the administrator and the quality assurance team for compliance. This will be completed by 8/31/2013 B.) 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	~~8/31/2013~~ 8/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 7/15/13

POC ACCEPTED W/ ROBERT FORD, ED, ON 7/22/13.

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SALF	Continued From page 1 were continuous from floor to roof. The findings were: Observation of the Memory Care West fire barrier wall on 6/17/13 between 4:30 PM and 5:30 PM showed four unsealed pipe penetrations in the attic. The largest gap measured 4 inches across. Further observation showed the Memory Care East fire barrier wall had two unsealed penetrations in the attic. The largest gap measured 2 inches by 4 inches. On 6/17/13 at 4:50 PM the maintenance director reported the fire barrier walls were not routinely inspected. Reference NFPA 101, 1994 Edition; 22-1.2 Mixed Occupancies. Where another type of occupancy occurs in the same building as a residential board and care occupancy, the requirements of 4-1.11 of the Code shall apply. Exception No. 1: Occupancies that are completely separated from all portions of the building used for a residential board and care facility and its egress system by construction having a fire resistance rating of at least 2 hours. B. Based on observation and staff interview, the facility failed to ensure the doors in 1 of 4 smoke barrier walls were smoke resistant. The findings were: Observation of the smoke barrier wall near the business office on 6/17/13 at 1:09 PM showed one of the two doors was not able to be fully latched into the door frame by the power of the attached self-closing device. At the time of the observation the maintenance director could not explain why the door had not been noticed and repaired during the monthly door checks. Reference NFPA 101, 1994 Edition;	SALF	This will be monitored quarterly for compliance by the environmental services director and the administrator. This will be completed by 8/31/2013. ~~8/31/2013~~ 8/16/13 C.) The environmental services director will install a self closing device on the kitchen dish washing room 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 to ensure compliance This will be monitored quarterly for compliance by the environmental services director and the QA team. This will be completed by 6/18/2012 ~~8/31/2013~~ 8/16/13 D.) We will have the curtains in the director of nursing office sprayed with flame retardant solution by the environmental services manager We will do a complete building wide check of all curtains to ensure compliance with the flame retardant spray and the proper documentation	

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SALF	Continued From page 2 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. C. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 4 smoke compartments. The findings were: Observation of the kitchen dish washing room on 6/17/13 at 1:58 PM showed the corridor door was not provided with a self-closing device. At the time of the observation the maintenance director reported he was unaware the door was required to be provided with a self-closing device. Reference NFPA 101, 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.	SALF	We will implement a quarterly check for all curtains to be completed by the environmental services staff including housekeepers. This will be monitored by the environmental services director and the QA team quarterly for compliance. This will be complete by 8/31/2013 ~~8/31/2013~~ 8/16/13 E.) 1.) The environmental services director will have the certified door company inspect the northeast door and ensure that the magnetic lock will release with 30 seconds of constant pressure. The EVS director will check all doors in the facility equipped with a magnetic lock to ensure they will release with 30 seconds of pressure. Each door will be checked quarterly by the EVS director and the administrator to ensure the doors are working properly. This will be checked quarterly by the QA team for compliance. This will be completed by 8/31/2013 ~~8/31/2013~~ 8/16/13 2.) The EVS director will hire a certified concrete company to extend the existing sidewalk to connect with a public way.	

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SALF	Continued From page 3 D. Based on observation and staff interview, the facility failed to ensure loose hanging fabric was flame retardant in 1 of 4 smoke compartments. The findings were: Observation of the director of nurses ' office on 6/17/13 at 1:46 PM showed flame retardant documentation was not attached to the two window curtains. At the time of the observation the maintenance director reported he did not have any flame retardant documentation for the aforementioned curtains. Reference NFPA 101, 1994 Edition; 31-7.5.1 New draperies, curtains and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 31-1.4.1. 31-1.4.1 Where required by the applicable provisions of this chapter, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame retardant as demonstrated by passing both the small- and large-scale tests of NFPA701 ... New Building A Life Safety Code survey was conducted at your facility on June 17-18, 2013 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a single story, fully sprinklered building of Type V (111) construction built in 2010. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 92 licensed beds. Wyoming Department of Health, Rules and Regulations for Licensure of Assisted Living	SALF	The EVS director will check all exits pathways to ensure it meets this regulation The EVS director will check these pathways annually to ensure they are in proper condition This will be monitored annually by the QA team for compliance. This will be complete by 8/31/2013 3.) The EVS director will bolt down the two winged back chairs near resident room #255 in order to have them in compliance and not be able to tip over and obstruct a pathway in an emergency. The EVS director will check all hallways to ensure wing backed chairs are properly secured. The EVS director will check all hallways quarterly to ensure all chairs are properly secured. This will be monitored quarterly by the QA team for compliance This will be completed by 8/31/2013 F.) We will have a sprinkler company hired to install the sprinkler head under the	~~8/31/2013~~ 8/16/13 ~~8/31/2013~~ 8/16/13

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SALF	Continued From page 4 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: --- E. Based on observation and staff interview the facility failed to ensure delayed egress locks were properly maintained, failed to ensure egress discharge pathways terminated at a public way, and failed to ensure furniture in egress corridors were secured to prevent obstruction in 4 of 4 smoke compartments. The findings were: 1. Observation of the northeast exit door on 6/17/13 at 3:04 PM showed the door was equipped with a magnetic delayed egress lock. Further observation showed the magnetic lock did not release with 30 seconds of constant pressure. The lock did release when the combination was entered into the key pad. At the time of the observation the maintenance director reported the delayed egress locks were not routinely inspected to ensure they would release when pressure was applied to the egress side of the door for more than 3 seconds.	SALF	canopy that is out of compliance mentioned in your findings. Going forward, any sprinkler heads that are installed will be benchmarked against the given speculations provided in your report. The EVS director will monitor all sprinkler heads after or before any installation going forward, at a minimum, annually. This will be monitored annually or upon any change or addition in sprinkler heads by the environmental services director and the QA team for compliance This will be corrected by 8/31/2013 G.) The EVS director will seal all pipe penetrations found in your report The EVS director will check all hazardous areas to ensure no other pipe penetrations exist These hazardous areas will be checked semi annually for compliance with this code. The QA team will monitor semi annually for compliance This will be completed by 8/31/2013	~~8/31/2013~~ 8/16/13 8/16/13 ~~8/31/2013~~

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SALF	Continued From page 5 2. Observation of the East exit discharge pathway on 6/17/13 at 3:23 PM showed the pathway was obstructed by a white vinyl fence. Further observation showed the gate to the white fence was locked from the inside as it is part of the newly renovated Memory Care unit. The East exit pathway did not terminate at a public way, nor did the South Memory Care courtyard discharge pathway. At the time of the observation the maintenance director reported he assumed the new design plan would have addressed the exit discharge pathways. 3. Observation of the second floor corridor on 6/17/13 at 3:58 PM showed two wing backed chairs were in the corridor alcove near resident room #255. Further observation showed the chairs were not secured to prevent them from tipping over and obstructing the corridor in the event of an emergency. At the time of the observation the maintenance director reported he was unaware of the aforementioned requirement. Reference NFPA 101, 2000 Edition, 32.3.2.1; 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. ...(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release	SALF	H.) The boxes in resident room #106 will be removed and cleared within 18 inches of the mentioned sprinkler head. All resident rooms and closets will be checked to ensure an 18 inch clearance of sprinkler heads by the EVS director Rooms will be checked quarterly by the EVS director to ensure compliance The QA team will monitor this quarterly to ensure compliance and safety This will be completed by 8/31/2013 I.) The EVS director will remove the E sized oxygen bottles not being used from room #100 and #106 The EVS director will also remove all E sized bottles that exceed 12 units, as that is the max allowable to be stored outside of a designated oxygen storeroom. The EVS director and the nursing department will check rooms monthly to ensure we are in compliance in regards to number of oxygen bottles in a room at one time. The QA team will monitor this quarterly to ensure compliance with this policy This will be completed by 8/31/2013	~~8/31/2013~~ 8/16/13 8/16/13 ~~8/31/2013~~

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SALF	Continued From page 6 process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Reference NFPA 101, 2000 Edition, 32.3.2.7; 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Reference NFPA 101, 2000 Edition, 4.5.3.2 Unobstructed Egress. In every occupied building or structure, means of egress from all parts of the building shall be maintained free and unobstructed. No lock or fastening shall be permitted that prevents free escape from the inside of any building other than in health care occupancies and detention and correctional occupancies where staff are continually on duty and effective provisions are made to remove occupants in case of fire or other emergency. Means of egress shall be accessible to the extent necessary to ensure reasonable safety for occupants having impaired mobility. F. Based on observation and staff interview, the facility failed to ensure sprinkler coverage under canopies in 1 of 4 smoke compartments. The findings were: Observation of the northwest garage exit on 6/17/13 at 3:42 PM showed the roof canopy measured 6 foot by 8 foot. Further observation showed the canopy was not provided with a sprinkler head. Observation of the main entrance showed it was provided with a sprinkler head. At the time of the observation the maintenance director reported he was unaware exterior	SALF	J.) The EVS director will remove the extension cords from room #106 The EVS director will check all resident rooms and common areas for the use of extension cords. These same areas will be checked monthly going forward by the environmental service staff. This will be monitored monthly as well by the environmental supervisor and the QA team for compliance. This will be complete by 8/31/2013	~~8/31/2013~~ 8/16/13

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SALF	Continued From page 7 canopies greater than 4 feet wide required sprinkler coverage. He also reported that the sprinkler contractor had not identified the lack of sprinkler coverage. Reference NFPA 101, 2000, 32.3.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft in width. Exception: Sprinklers are permitted to be omitted where the canopy of roof is of noncombustible or limited combustible construction. Memory Care Unit A Life Safety Code survey was conducted at your facility on June 17-18, 2013 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a two story, fully sprinklered building of Type V (111) construction built in 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 25 licensed. 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 Health Care,	SALF		Ø

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SALF	Continued From page 8 2000 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: --- G. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 3 smoke compartments. The findings were: Observation of the main mechanical room on 6/17/13 at 2:07 PM showed three unsealed pipe penetrations. The largest gap measured 1 ½ inches across. At the time of the observation the maintenance director reported hazardous areas were not routinely inspected to ensure penetrations are sealed. Reference NFPA 101, 2000; 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 H. Based on observation and staff interview, the facility failed to ensure sprinkler heads were unobstructed in 1 of 3 smoke compartments. The findings were: Observation of resident room #106 on 6/17/13 at 2:36 PM showed the sprinkler head in the closet	SALF		

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SALF	Continued From page 9 was obstructed by two cardboard boxes. The boxes were located 10 inches below the sprinkler head. At the time of the observation the maintenance director reported he was aware stored items were required to be maintained at 18 inches below sprinkler heads. He could not explain why the cardboard boxes were not noticed and removed during the monthly safety inspections. Reference NFPA 101, 2000 Edition, 18.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-5.6 Clearance to storage. The clearance between the deflector and the top of storage shall be 18 in. or greater. I. Based on observation and staff interview, the facility failed to ensure oxygen cylinders were stored properly in 2 of 3 smoke compartments. The findings were: Observation on 6/17/13 between 2 PM and 3 PM showed (36) "E" sized oxygen cylinders were being stored in resident room #100. Further observation showed (20) "E" sized oxygen cylinders were being stored in resident room #106. On 6/17/13 at 2:26 PM the maintenance director reported he was unaware that only oxygen cylinders in use could be stored in the resident room as the Memory Care unit was classified as Health Care occupancy. He was also unaware only (12) "E" sized oxygen cylinders (300 cubic feet) could be stored outside of a designated oxygen storeroom per smoke compartment. Reference NFPA 101, 2000 Edition, 18.3.2.3, NFPA99, 1999 Edition; 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft3.	SALF		6

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SALF	Continued From page 10 (a) Storage locations shall be ...within an enclosed interior space or noncombustible or limited-combustible construction, with doors that can be secured against unauthorized entry. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustible or incompatible material by either: 1. A minimum of distance of 20 ft., or 2. A minimum distance of 5 ft if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, standard for the installation of sprinkler systems, ... 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft, shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING J. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed electrical wiring in 1 of 3 smoke compartments. The findings were: Observation of resident room #106 on 6/17/13 at 2:35 PM showed the television set was plugged into an extension cord. At the time of the observation the maintenance director could not explain why the extension cord had not been noticed and removed during the daily room inspections. Reference NFPA 101, 2000 Edition, 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	SALF		6

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW WIND ASSISTED LIVING COMMUNIT	3955 EAST 12TH STREET CASPER, WY 82609

(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 11 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	SALF		