PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 This State Rules and Regulations is not met as evidenced by: A Life Safety Code survey was conducted at your facility on July 17, 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 2006. The building was equipped with a supervised, automatic wet 13 R sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 16 licensed beds with a census of 12 residents. Wyoming Department of Health Aging Division Rules 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	SALF		

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

8/5/13

STATE FORM 6899 EZYY11 If continuation sheet 1 of 14

President

8/20/13

Pre-Accepted w/ Cheryl Wilkins, President. on 8/21/13.

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	824 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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 1 facility failed to ensure hazardous areas were separated from use areas in 2 of 6 hazardous locations. The findings were: 1. Observation of the hot water heater room on 7/17/13 at 9:51 AM showed three unsealed pipe penetrations. The largest gap measured ¾ of an inch across. At the time of the observation, the manager reported hazardous areas were not routinely inspected to ensure penetrations were sealed. 2. Observation of the kitchen pantry on 7/17/13 at 10:19 AM showed the corridor door was obstructed by a large wood block. Once the block was removed, the self-closing device attached to the door was not able to fully latch the door into the door frame, with three attempts. At the time of the observation, the manager reported she was unaware the wood block was prohibited. She was also unaware that doors to all storage rooms were required to fully latch into the door frame with the power of the installed self-closing device. Reference NFPA 101, 2000 Edition; 32.2.3.2 Protection from Hazards. Any hazardous area shall be protected in accordance with 32.2.3.2.1 and 32.2.3.2.3. 32.2.3.2.2 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 one of the following means. (a) Protection shall be an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic-closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than 3/4 hour. The enclosure shall be protected by an automatic fire detection system connected to the fire alarm system provided in 32.2.3.4.1.	SALF	A. The facility will ensure that all pipe penetrations will be properly filled in accordance with NFPA 101, 2000 Edition. Contractor will routinely inspect hazardous areas to ensure penetrations remain sealed. Contractor will submit quarterly reports to facility. B. Self-closing devices will be monitored to ensure that they fully latch into the door frame with the power of the installed self-closing device. Manager will monitor for compliance.	09/15/2013

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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 2 (b) Protection shall be automatic sprinkler protection, in accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation shall be self-closing or automatic-closing in accordance with 7.2.1.8. B. Based on observation, record review, and staff interview, the facility failed to ensure 4 of 4 battery powered emergency egress lights were operational and failed to ensure 2 of 2 emergency battery light tests were performed. The findings were: 1. Observation of the west corridor on 7/17/13 at 11:25 AM showed neither of the two battery powered emergency egress lights would illuminate once the test button was depressed. Further observation showed neither of the two battery powered emergency egress lights would illuminate when tested, in the east corridor. At the time of the observation the manager could not explain why the lights failed. 2. Review of the emergency battery light testing records showed the monthly 30 second test was last performed on 1/19/13. Review also showed the facility did not have record of the last time the annual 90 minute test was last performed. On 7/17/13 at 11:20 AM the manager confirmed she did not have any other records to review. Reference NFPA 101, 2000 Edition; 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature	SALF	The facility will ensure that the battery powered emergency egress lights illuminate once the test button is depressed, and that testing is completed monthly for 30 second testing and 90 minute testing annually. Reports of the testing will be kept on file at the facility Manager will monitor for compliance.	09/15/13

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 3	SALF		

shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 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 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.

C. Based on observation, record review, and staff interview, the facility failed to ensure escutcheon rings maintained a continuous smoke barrier, failed to ensure exposed CPVC sprinklers piping were attached to the building surface, and failed to ensure sprinkler tests were performed during the last two quarters. The findings were:

1. Observation of the television room on 7/17/13 at 9:17 AM showed 1 of 8 sprinkler heads was missing the escutcheon ring. At the time of the observation, the manager was unaware the escutcheon ring was required to maintain a smoke resistant barrier for sprinkler activation. She was unsure if the sprinkler maintenance technician reviewed each sprinkler head to ensure they were in proper working order.

2. Observation of the hot water heater room on 7/17/13 at 9:51 AM showed the main sprinkler riser was constructed of a 3 inch CPVC orange pipe. Further observation showed the pipe was 5 feet long and was 10 inches away from the nearest wall. On 7/17/13 at 11:20 AM the owner reported that he was unaware exposed CPVC

A. The facility will ensure that all sprinkler head escutcheon rings are in place in accordance with NFPA 101, 2000 Edition.

B. The facility will ensure that the CPVC pipe for the main sprinkler riser is mounted directly to the building surface as per NFPA 101, 2000 Edition.

C. Sprinkler system testing (supervisor signal devices and waterflow devices) will be completed quarterly by contractor.

Contractor will complete testing records to be kept at the facility.

Manager will monitor for compliance. 09/15/2013

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 4	SALF		

pipe was required to be installed adjacent to a building surface.

3. Review of the sprinkler system testing record showed the quarterly waterflow and supervisory signal devices were last tested on 12/15/12, more than 6 months ago. On 7/17/13 at 11:20AM the owner could not explain why the testing records were not in the maintenance and testing folder. He could not verify if the tests had been performed.

Reference NFPA 101, 2000 Edition, 32.2.3.5.2, 9.7.1.1, NFPA 13, 1999 Edition;
3-2.7.2 Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.
3-3.6 Other types of pipe or tube investigated for suitability in automatic sprinkler installations and listed for this service, including but not limited to polybutylene, CPVC, and steel differing from that provided in Table 3-3.6 shall be permitted where installed in accordance with their listing limitations, including installation instructions ... Harvel Blazemaster manufactures installation guide for exposed installation stated " Pendent Sprinklers Light Hazard or Residential Pendent Sprinklers ...The piping shall be mounted directly to the building surface " .
Reference NFPA 101, 2000 Edition, 32.2.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition;
Table 7-3.2 Testing Frequencies.
15. Initiating Devices
j. Supervisory Signal Devices, ... quarterly
k. Waterflow Devices, ... quarterly

D. Based on observation and staff interview, the facility failed to ensure 1 of 2 designated smoking areas were provided with safe type ashtrays. The findings were

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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-5	SALF		

Observation of the back patio on 7/17/13 at 9:42 AM showed the smoking area was provided with open top ashtrays. This type of ashtray is not designated as a safe type as the wind could blow the cigarette butts or hot ash out of the tray. At the time of the observation, the manager was unaware open ashtrays were not considered safe.

Reference NFPA 101, 2000 Edition; 32.7.4.2 Where smoking is permitted, noncombustible safety-type ashtrays or receptacles shall be provided in convenient locations.

A. The facility will ensure that all smoking areas have a noncombustible safety-type ashtray provided in convenient locations.

Manager will monitor for compliance. 09/15/2013

E. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring. The findings were:

Observation of the laundry room on 7/17/13 at 10:24 AM showed both of the clothes driers were plugged into an orange extension cord. Further observation showed electrical receptables were not located behind the dries, so an extension cord was required because of lack of accessibility. At the time of the observation, the manager could not explain why new electrical receptacles were not installed so that the extension cord was not needed.

Reference NFPA 101, 2000 Edition, 32.2.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following:
(1) As a substitute for the fixed wiring of a structure
(2) Where run through holes in walls ...

A. The facility will ensure that temporary electrical wiring does not replace permanent fixed wiring in accordance with NFPA 101, 2000 Edition.

Permanent wiring will be placed in the laundry room for the dryer connections.

Manager will monitor for compliance. 09/15/2013

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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 6 (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces F. Based on policy review and staff interview, the facility failed to ensure 2 of 7 emergency policies were provided. The findings were: Review of the emergency preparedness policies showed the facility did not have a fire watch policy for the impairment of the fire alarm system or sprinkler system. On 7/17/13 at 9 AM the manager reported she did not have a fire watch policy to review. On 7/17/13 at 10:04 AM the sprinkler system was shut off at the main riser because of a leaking pipe above the east furnace room. Interview with certified nurses assistant #1 reported she was aware the sprinkler system was not operational and that an hourly inspection of the facility was being performed. On 7/17/13 at 10:16 AM the owner reported that he was unsure if the facility had a written fire watch policy. He also reported that he was aware the sprinkler system was not operational since 7/12/13, but the local fire department had not been notified of this fact nor was the state health department. He was unaware these governing bodies were required to be notified when a life safety system was impaired. Reference NFPA 101, 2000 Edition, 32.2.3.5.2; 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. Reference NFPA 101, 2000 Edition, 32.2.3.4.1;	SALF	A. The facility will develop a fire watch policy. The staff will be training on the policy by the manager. Manager will monitor for compliance.	09/15/2013

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 7	SALF		

9.6.1.8* Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. Reference NFPA 101, 2000 Edition, 32.2.3.5.2, 9.7.5, NFPA 25, 1998 Edition;
11-3.1 A tag shall be used to indicate that a system, or part thereof, has been removed from service.
11-3.2 The tag shall be posted at each fire department connection and system control valve indicating which system, or part thereof, has been removed from service. The authority having jurisdiction shall specify where the tag is to be placed.
11-5 Preplanned Impairment Programs. All preplanned impairments shall be authorized by the impairment coordinator ...
(b) The areas of buildings involved have been inspected and the increased risks determined.
(c)Recommendations have been submitted to management or building owner/manager. Where a required fire protection system is out of service for more than 4 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following:
1. Evacuation of the building or portion of the building affected by the system out of service.
2. An approved fire watch
(d) The fire department has been notified
(e) The insurance carrier, the alarm company, building owner/manager, and other authorities having jurisdiction have been notified.
(f) The supervisors in the areas to be affected have been notified ...
(g) A tag impairment system has been implemented (see Section 11-3.)

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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 9	SALF		

11-7 Restoring System to Service. When all impaired equipment is restored to normal working order, the impairment coordinator shall verify that the following procedures have been implemented:
(a) Any necessary inspections and test have been conducted ...
(b) Supervisors have been advised that protection is restored.
(c) The fire department has been advised that protection is restored.
(d) The building owner/manager, insurance carrier, alarm company, and other authorities having jurisdiction have been advised that protection is restored.
(e) The impairment tag has been removed.

Wyoming Department of Health Aging Division Rules
Program Administration of Assisted Living Facilities Chapter 12
Section 7. Assisted Living Facility (ALF) Core Services.
(n) Furnishings, Buildings, Physical Plant.
(ii) Sleeping rooms shall be homelike, well lighted, ventilated and equipped in compliance with the requirements below;
(Z) Portable space heaters shall not be used, (e.g. electric or kerosene).

This regulation was NOT MET as evidenced by:

G. Based on observation and staff interview, the facility failed to ensure portable space heaters were not used in 2 of 14 resident rooms. The findings were:

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/2/13

(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 9	SALF		

Observation on 7/17/13 between 10:30 AM and 11 AM showed portable space heaters were in resident room #7 and #11. On 7/17/13 at 10:35 AM the manager reported she was aware portable space heaters were prohibited. She also reported that resident rooms were not routinely inspected for space heaters, but that staff members were in resident rooms nearly every day. She could not explain why staff members had not noticed and removed the aforementioned space heaters.

A. The facility will ensure portable space heaters are not used within the facility.

Manager will monitor for compliance. 09/15/2013

Wyoming Department of Health Aging Division Rules
Program Administration of Assisted Living Facilities Chapter 12
Section 7. Assisted Living Facility (ALF) Core Services.
(o) Evacuation Capability, Emergency Procedures, and Fire Safety.
(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;

A. The facility will ensure that fire exit drills will be completed at a minimum of one drill each quarter on each shift.

The documentation will include the date of drill, time of day, type of drill, participants, time required, comments, signature and date of person completing the evaluation.

Manager will monitor for compliance. 09/15/2013

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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-	SALF		

(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 evidenced by:

H. Based on observation and staff interview, the facility failed to ensure fire drills were held on each shift on 3 of the past 4 quarters. 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 on the third shift during the fourth quarter of 2012 and the first and second quarters of 2013. On 7/17/13 the manager could not explain why the previous manager had not conducted fire drills on the third shift for the aforementioned quarters.

Wyoming Department of Health Aging Division Rules
Program Administration of Assisted Living Facilities Chapter 12

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

(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	SALF		

Section 7. Assisted Living Facility (ALF) Core Services.
(c) 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
(ii) 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;
(6.) 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

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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 12	SALF		

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

This regulation was NOT MET as evidenced by:

I. Based on observation and staff interview, the facility failed to ensure 1 of 12 residents was not capable of evacuation without assistance. The findings were:

Observation of a fire drill on 7/17/13 at 11:26 AM showed the resident in room #14 was not capable of evacuation without staff assistance. Two staff members were required to remove the resident from his hospital grade bed and transfer him into a wheelchair. On 7/17/13 at 11:33 AM the certified nurses assistant #1 confirmed the resident was not able to transfer himself to a wheelchair without staff assistance. On 7/17/13 at 11:35 PM the manager reported she was unaware residents that were not capable of evacuation without assistance were not eligible residents in assisted living facilities.

Reference NFPA 101, 2000 Edition;
32.7.3 Emergency Egress and Relocation Drills.
... The drills shall involve the actual evacuation of all residents to an assembly point as specified in the emergency plan and shall provide residents with experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any drill shall not be

The facility will ensure residents are capable of evacuation with minimal assistance.

A) Resident in room #14 has been given (along with family) the options to have 24 hour caregiver assistance provided by the family to assist with evacuation if the resident is unable to evacuate by himself.
B) If the resident chooses not to accommodate the request (A) then the resident will be given the notice that they are no longer able to stay at the facility and will need to find new placement by 08/31/2013.
C) The staff will provide intermittent assistance if needed for any resident. If a resident is unable to be assisted intermittently a plan of correction will be implemented to facilitate independence by utilizing home health therapies or 24 hour assistance provided by family.
D) The facility will ensure that all residents are able to evacuate with intermittent assistance. If resident changes in condition or noted the facility will schedule a physician

PRINTED: 07/26/2013
FORM APPROVED

Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF011	A. BUILDING: _____ B. WING _____	07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER HEART ASSISTED LIVING FACILITY	624 TWIN RIDGE AVENUE EVANSTON, WY 82930

8/21/13

(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 13	SALF		
	credited in meeting the requirements of this Code for board and care facilities. Exception No. 2: If the board and care facility has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to actively participate in the drill. Section 18.7 shall apply in such instances.		consult to obtain home health assistance with independence. If the resident is not able to become independent the facility will notify the family of the residents inability to continue placement in assisted living and will need be given a 30 day notice of intent to transfer to a skilled nursing facility.	09/15/13