STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

(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 May 8, 2012 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a one story fully sprinkled building of Type V (111) construction built in 1996. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and a zoned fire alarm system. The facility had a capacity of 48 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 ceilings were smoke resistant in 1 of 4 smoke compartments. The findings were:	SALF	(A) It is the practice of this facility to follow the Life Safety Codes. NFPA 101: Life Safety Code 22-3.1.3.1 1. The maintenance director installed sheathing around the unsealed ceiling area located in the south hot water heater room. The sheathing covers the area to prevent unsealed ceiling penetrations to meet the regulations of Life Safety Code. 2. Inspections will be performed quarterly by the maintenance director utilizing quarterly maintenance Life safety review. Documentaion 3. Life Safety review will be addressed at the monthly safety committee meeting and any trends , patterns or deficiencies will be reported to the administrator. The maintenance director will schedule all repairs to bring the building back into compliance. 4. Completion Date: May 10, 2012	5/10/12

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

POC ACCEPTED WITH LIZ KEISER-THOMPSON, ADMINISTRATOR, ON 6/25/12.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

(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	SALF		

Observation of the south hot water heater room on 5/8/12 at 2:23 PM showed there were three unsealed ceiling penetrations. The largest gap measured 2 inches across. At the time of the observation the maintenance director could not explain why the penetrations had not been noticed and sealed during the annual inspection.

Reference;
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 material providing a 15-minute thermal barrier.

B. Based on observation and staff interview, the facilities failed to ensure 1 of 4 smoke barrier doors were smoke resistant. The findings were:

Observation of the northwest smoke barrier door on 5/8/12 at 3:46 PM showed the strike plate had been displaced and the latch bolt was unable to insert into the strike plate and latch the door into the door frame. At the time of the observation the maintenance director could not explain why the door had not been noticed and repaired during the quarterly safety inspection.

Reference;
22-3.3.6.5 Walls and doors required by 21-3.3.6.1 and 21-3.3.6.2 shall be constructed to resist the passage of smoke....

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:

NFPA 101 Life Safety Code-22.3.3.6.5, 21-3.3.6.1, 21-3.3.6.2

1.The strike plate on the Northwest smoke barrier door has been repaired by the Maintenance director to ensure that the latch bolt inserts into the strike plate allowing the door to latch to the door frame correctly to meet the Life Safety Code.

2. Safety Inspections of the building will be conducted quarterly by the maintenance director

3. Deficiencies found on these quarterly inspections will be reported to the Administrator and addressed during the monthly Quality Assurance meeting. The maintenance director will schedule all repairs to bring the building back into compliance.

4. Completion Date: May 10, 2012

NFPA 101 Life Safety Code-22-3.3.2.2

1. The Maintenance director removed the wedge placed under the door on the South laundry room. A notice has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

(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	SALF	placed on the door stating that the door shall remain closed at all times. Staff and Residents will be reminded that this door should not be obstructed as well as any other fire door. 2. The Maintenance director will check the doors on periodic rounds throughout each month. Staff has been educated on the importance of keeping these smoke barrier doors remain closed at all times. 3. Staff is to report to Administrator immediately if deficiency is found. It will be addressed in the monthly Quality Assurance meeting. 4. Completion Date: May 9, 2012	

Observation of the south laundry room on 5/8/12 at 2:31 PM showed the corridor door was impeded by a wedge placed under the door. At the time of the observation the maintenance director reported the staff and residents have been instructed to not impede the door.

Reference;
22-3.3.2.2 Every hazardous area shall be separated from other parts of the building by construction having a fire resistance rating of at least 1 hour, with communicating openings protected by approved self-closing fire doors, or such area shall be equipped with automatic fire extinguishing systems. 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

---

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

(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		

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 the form.

This regulation was NOT MET as evidenced by:

D. Based on policy review, record review, and staff interview, the facility failed to ensure the fire drill policy addressed complete evacuation of the building with each fire drill and failed to ensure complete evacuation occurred during 8 of the past 12 fire drills. The findings were:

1. Review of the fire policy stated "Move to your

FIRE SAFETY

1. Effective June 7, 2012, the Fire Policy in the community STATES that fire drills will require all residents, including staff and visitors to evacuate from the occupied areas to a point of assembly to meet the regulations of the Life Safety Code.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF002	A. BUILDING _____ B. WING _____	05/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN SQUARE OF CASPER	1950 SOUTH BEVERLY STREET CASPER, WY 82601

(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		

nearest unblocked exit from where you are located, and wait for a member of the fire department or staff to give you instructions." On 5/8/12 at 1:30 PM the administrator reported she was unaware resident were required to evacuate during each fire drill.

2. Review of the fire drills showed complete evacuation only occurred during April, May, June, and December 2011. On 5/8/12 at 4:20 PM the maintenance director reported he was unaware complete evacuation was required during every drill. At 1:30 PM the administrator reported she thought full evacuation was only required once a quarter.

Reference, 22-3.5 Operating Features. (See Chapter 31.)
31-7.3 Fire Exit Drills. Fire exits drills shall be conducted at least six times per year on a bi-monthly basis with a minimum of two drills conducted during the night when residents are sleeping. The drills shall be permitted to be announced in advance to the residents. 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 the experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of this Code for board and care facilities.

2. The staff and residents will be provided with training on such evacuation over the next 30 days, and the next scheduled fire drill will include evacuation from occupied areas to a point of assembly.

3. Maintenance director will conduct monthly fire drills per community policy utilizing our Fire Drill Reporting form. Non-Compliance will be reviewed and managed by the administrator

4. Documentation of Drills will be on file for review.

5. Completion Date: June 30, 2012.