PRINTED: 01/18/2012
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
	ALF006	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN WIND ASSISTED LIVING COMMUNITY	4010 NORTH COLLEGE DRIVE CHEYENNE, WY 82001

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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 January 5, 2012 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a single story fully sprinkled building of Type V (111) construction built in 1998 and 2010. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had two, level 2 memory care units and one, level 1 assisted living unit with a capacity of 94 licensed beds and a total census of 44 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, 2000 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: A. Based on observation, blue print review, and	SALF		

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

STATE FORM 6899 X80S11 If continuation sheet 1 of 7

Sarah Gibson Exec Dir 01/31/2011

POC MODIFIED & ACCEPTED W/ SARAH GIBSON, EXECUTIVE DIRECTOR ON 2/9/12.

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SALF	Continued From page 1 staff interview, the facility failed to ensure corridor doors were smoke resistant and failed to ensure corridor doors were solid core doors in 2 of 7 smoke compartments. The findings were: 1. Observation of the memory lane diagonal separation wall on 1/5/12 at 8:52 AM showed the access door was hollow core. At the time of the observation the maintenance director reported he was unaware all corridor doors were required to be solid core doors. Review of the blue prints on 1/6/12 at 10 AM showed the door was supposed to be a solid wood door with a wire glass vision panel. 2. Observation of the director of nursing office on 1/5/12 at 9:50 AM showed the corridor door was obstructed from closing by a rubber wedge placed under the door. At the time of the observation the maintenance director could not explain why the wedge was used. He also reported staff members were regularly trained to not obstruct corridor doors. Reference; 32.3.3.6.4 Doors in walls required by 32.3.3.6.1 or 32.3.3.6.2 shall have a fire protection rating of not less than 20 minutes. --- B. Based on observation and staff interview, the facility failed to ensure 1 of 4 fire barrier walls were continuous from floor to ceiling. The findings were: Observation of the southwest precious memories attic fire barrier wall on 1/5/12 at 10:30 AM showed there were two unsealed cable penetrations. The largest penetration measured 2	SALF	A. 1. The solid core, smoke and fire rated door will be installed. ~~3/16/12~~ 3/15/12 All doors will be monitored for fire and smoke rating by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 2. Rubber wedge was replaced with magnetic door stops on the DON office door. 1/3/12 All doors will be monitored for door wedges by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. B. Cable penetrations were patched and sealed. 1/31/12 All penetrations will be monitored by the environmental services manager's quarterly quality assurance; and issue will be documented, corrected and reported to the QA program.	

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SALF	Continued From page 2 inches by 5 inches. At the time of the observation the maintenance director reported he had not inspected attic barriers since the final inspection was completed in June 2011. Reference; 18.1.2.1* Sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. (2) They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours. C. Based on observation, blue print review, and staff interview, the facility failed to ensure egress pathways had adequate head room in 3 of 7 smoke compartments. The findings were: 1. Observation of fire barrier double doors on 1/5/12 between 9 AM and 10 AM showed the memory lane north double doors and the precious memories south double doors were equipped with magnetic locking devices. Further observation showed the bottom of the magnetic lock was 6 feet 5 inches above the ground, not the required 6 foot 8 inches. Review of the door frame showed it measured 6 foot 8 inches. At 9:23 AM the maintenance director reported he was unaware of the aforementioned head room requirement. 2. Observation of the precious memories dining room on 1/5/12 at 10:03 AM showed the bottom of two light fixtures in the path of travel measured	SALF	C. 1. Magnetic locking devices will be placed at proper height. 3/16/12 All doors will be monitored for proper placement of locking devices by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 2. Light fixtures will be raised to proper egress height. 3/16/12 All light fixtures will be monitored to ensure proper egress by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 3/5/12	

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SALF	Continued From page 3 6 feet 2 inches above the floor. Review of the blue prints at 11 AM showed the lights were supposed to be located above tables, but the table had been moved. At the time of the observation the maintenance director reported the tables were moved for convenient travel to the kitchen area. Reference, 18.2.1; 7.1.5* Headroom. Means of egress shall be designed and maintained to provide headroom as provided in other sections of this Code and shall be not less than 7 ft 6 in. (2.3 m) with projections from the ceiling not less than 6 ft 8 in. (2 m) nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two-thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft 8 in. (2 m). Headroom on stairs shall be not less than 6 ft 8 in. (2 m) and shall be measured vertically above a plane parallel to and tangent with the most forward projection of the stair tread. D. Based on observation, blue print review, and staff interview, the facility failed to ensure sprinkler heads were properly installed in 1 of 7 smoke compartments. The findings were: 1. Observation of the sprinkler system on 1/5/12 at 9:44 AM showed the sprinkler head in the marketing office was located 2 inches from a wall. Review of the blue print at 11 AM showed a wall had been erected and the sprinkler head was not moved to the required 4 inches from a wall. Further observation at 9:47 AM showed the other side of the wall was the director of nursing office. The sprinkler head in this room was located more	SALF	D. 1. All sprinklers will be moved to proper distance from wall. 3/16/12 All sprinkler heads will be monitored to ensure proper placement by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 2. Sprinkler heads will be moved to provide adequate sprinkler coverage in Precious Memory's dining room. 3/16/12 All sprinkler heads will be monitored to ensure proper placement by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 3/15/12	

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SALF	Continued From page 4 than the allowed 9 feet from a wall. The head measured 11 feet for the far wall. 2. Observation of the sprinkler system on 1/5/12 at 9:53 AM showed five sprinkler heads in the precious memories dining room did not provide adequate sprinkler coverage. One head was located 11 feet for a wall, four heads were located 17 feet apart and two heads were located 18 feet apart. At the time of the observations the maintenance director reported he assumed the general contractor would have assured the area had adequate sprinkler coverage. Reference, 18.3.5.1, 9.7.1.1, NFPA 13,I 1999 Edition; 5-5.3.1 Maximum Distance Between Sprinklers. The maximum distance permitted between sprinklers shall be based on the centerline distance between sprinklers on the branch line or on adjacent branch lines. The maximum distance shall be measured along the slope of the ceiling. The maximum distance permitted between sprinklers shall comply with the value indicated in the section for each type or style of sprinkler. 5-5.3.2 Maximum Distance From Walls. The distance from sprinklers to walls shall not exceed one-half of the allowable maximum distance between sprinklers. The distance from the wall to the sprinkler shall be measured perpendicular to the wall. Table 5-6.2.2 (b) Protection Areas and Maximum Spacing (Standard Spray Upright/Standard Spray Pendent) for Ordinary Hazard Construction Type ... ...All System Type ... ...All Protection Area ... ...130 ft2 Spacing ... ...15 ft 5-6.3.3 Sprinklers shall be located a minimum of 4 in. from the wall.	SALF		

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SALF	Continued From page 5 E. Based on observation and staff interview, the facility failed to ensure loose hanging draperies and decorations were flame retardant in 3 of 7 smoke compartments. The findings were: 1. Observation on 1/5/12 at 8:28 AM showed a cotton quilt was hanging on the wall in resident room #217. Further observation showed flame retardant documentation was not attached to the quilt. At the time of the observation the maintenance director reported the quilt was not flame retardant and a flame retardant solution had not been applied to the fabric. He could not explain why the quilt had not been noticed and treated with a flame retardant solution during the quarterly safety inspections. 2. Observation on 1/5/12 at 9:01 AM showed two lavender wreaths were hanging in the memory lane corridor. Further observation showed the lavender stems were dry and brittle. At the time of the observation the maintenance director reported he was unaware dry plant based wreaths were prohibited. Reference: 18.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. G. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 7 smoke compartments. The findings were:	SALF	E. 1. Quilt was sprayed with Flame Busters fire retardant. Fabric materials will be monitored to ensure proper fire retardant by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program. 2. Lavender wreaths were removed. Decorations will be monitored to ensure proper fire retardant by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program.	1/6/12 1/6/12

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SALF	Continued From page 6 Observation of the electrical system on 1/5/12 at 8:34 AM showed the refrigerator and toothbrush charger in resident room #205 were plugged into a 3-way adapter. At the time of the observation the maintenance director could not explain why the adapter had not been noticed and removed during the quarterly inspections. Reference, 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 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	G. Three way plug was removed from resident apartment. Three way plugs will be monitored for by the environmental services manager's quarterly quality assurance; and issues will be documented, corrected and reported to the QA program.	1/5/12