WDH - Office of 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 _____	07/12/2011

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	SALF		

This State Rules and Regulations is not met as evidenced by:
A survey was conducted at your facility on July 12, 2011 by the Office of Healthcare Licensing and Surveys (OHLS).

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 13 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.

MESSAGE FOR WAYNE JOHNSON, OWNER ON 8/29/11

All references are based on the requirements of NFPA 101, Life Safety Code, 2000 edition, unless otherwise noted.

This regulation was NOT MET as evidence by:

ORIGINAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: OWNER | (X6) DATE: 8-6-11

STATE FORM 6899 GZEC11 If continuation sheet 1 of 10

POC ACCEPTED W/ WAYNE JOHNSON, OWNER, ON 8/29/11.

RECEIVED
Wyoming Dept of Health
AUG 25 2011
Office of Healthcare Licensing and Surveys

8-19-11

WDH - Office of Healthcare Licensing and Surveys

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SALF	Continued From page 1	SALF		

A. Based on observation and staff interview the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 3 of 3 smoke compartments. The findings were:

Observation of the portable fire extinguishers on 7/12/11 between 10:30 AM and 12:30 PM showed the last annual inspection occurred during May 2011. Further review showed the monthly inspection had not been performed for June 2011. At 10:53 AM the manager reported she was unaware of the monthly inspection. She also reported monthly inspections have never been conducted since the facility was opened in April 2002.

Reference:
4.6.12.1, 9.7.4.1, NFPA 10, 1998 edition;
4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals ....

B. 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 on 7/12/11 between 11 AM and 11:30 AM showed the mechanical room had two unsealed pipe penetrations and the maintenance room had five unsealed wall penetrations. The largest gap was 1 inch wider than the pipe running through the hole. At 11 AM the manager reported she was unaware hazardous areas required a smoke partition. Furthermore, she reported the building was not routinely inspected for penetrations.

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.

There was no effect on the residents because no fire extinguisher was found to be defective upon inspection. This was simply a frequency and documentation issue

The monthly fire extinguisher checks have been placed into the quality assurance program as well as training for each employees followed by signed documentation of that training. The assisted care will also follow up quarterly in the fire book to ensure compliance with the applicable regulations. 9/01/11

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.

Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

The effect on residents was minimal because no fire hazards were observed.

All areas noted in the deficiencies were corrected using fire foam on 8-07-2011
The routine checks will be placed into the quality assurance program for the safety contractor fire check list. The assisted care will also follow up on the contractors quarterly inspections to ensure compliance with the applicable regulations. To complete by 9-01-2011 9/01/11

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WDH - Office of Healthcare Licensing and Surveys

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SALF	Continued From page 2	SALF		

Reference:
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.
(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.

C. Based on observation and staff interview the facility failed to ensure window curtains were flame retardant in 1 of 3 smoke compartments. The findings were:

Observation on 7/12/11 between 11 AM and 12:30 PM showed the window curtains in resident room #111 and #109 did not have flame retardant documentation attached to them. At 11:25 AM the manager confirmed the facility did not have flame retardant documentation for the aforementioned curtains. She stated she was unaware window curtains were required to be flame retardant.

Reference:
32.7.5.1;
10.3.1 Where required by the applicable

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.

Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

The residents that have curtains in their room will have flame retardant sprayed on their curtains/draperies and tagging identification of each curtain will be attached for documentation . This will also be added to the quality assurance program and followed up on with each new admission. To complete by 9-01-2011

9/01/11

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SALF	Continued From page 3	SALF		

provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.

D. Based on observation and staff interview the facility failed to ensure electrical equipment had adequate work space and failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 3 smoke compartments. The findings were:

1. Observation of the maintenance room on 7/12/11 at 11:06 AM showed three electrical circuit panels were obstructed. The facility had stored tools, cardboard boxes, and supplies directly in front of the panels. At the time of observation the manager reported she was unaware electrical equipment required 3 feet of work space.

2. Observation of the electrical system on 7/12/11 between 11:30 AM and 12 PM showed the refrigerator in the medication room was plugged into two connected surge protectors. Further review showed the microwave oven in resident room #127 was plugged into an extension cord. At 11:39 the manager reported she was aware electrical adapters were prohibited. She also reported each room was inspected on a monthly basis, she could not explain why the aforementioned adapters had not been indentified and removed.

Reference:
32.2.5.1, 9.1.2, NFPA 70, 1999 edition article;

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.
Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

There was no effect on the residents because no hazard was requiring imminent access.
Travelway access checks have been placed into the quality assurance program as well as training for each employee followed by signed documentation of that training. Signs will also be posted at each panel. The assisted care will also follow up quarterly in the fire book to ensure compliance with the applicable regulations

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.
Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

An electric contractor has been contacted and XXX Electric is currently working on a schedule to install permanent GFI outlets in the medication room.

Residents affected were established to only 1 room. Follow up inspections will be performed through employee training and adjustment to the quality assurance program. To complete by 9-12-2011
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SALF	Continued From page 4	SALF		

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 To Ground	Minimum Clear Distance (ft)
0/150	3 ft.

(b) Clear Space. Working space required by this section shall not be used for storage ...
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

E. Based on observation, record review, and staff interview the facility failed to ensure strobes were synchronized in 1 of 3 smoke compartments and failed to ensure 7 of 7 fire alarm system components were tested on an annual basis. The

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SALF	Continued From page 5	SALF		

findings were:

1. Observation of the fire drill on 7/12/11 at 2:09 PM showed the four strobes in the living room where all in the same line of sight. Further review showed the flashing lights where not synchronized. At the time of observation the manager reported she was unaware of the aforementioned requirement.

2. Review of the fire alarm system testing records showed the system had not been tested within the past year. The system was last tested on 5/05/10. The bi-annual smoke detector sensitivity test was last performed on 4/7/09, more than two years ago. On 7/12/11 at 2:05 PM the manager reported she expected the contractor to complete the tests on a regular schedule, but she did not contact them to confirm the schedule.

Reference:
32.2.3.4.1, 9.6.1.4, NFPA 72, 1999 edition;
4-4.4.1.1 Strobe Spacing shall be:
4. More than two in the same field of view shall be synchronized.
Table 7-3.2 Testing Frequencies.
15. Initiating Devices
a. Duct Detectors, ...annually
f. Fire Alarm Boxes, ...annually
h. All Smoke Detectors,.....annually
i. Smoke Detectors-
Sensitivity, ...bi-annually
j. Supervisory Signal
Devices,.....quarterly
k. Waterflow Devices,.....quarterly
19. Alarm Notification Appliances
a. Audible Devices,.....annually
c. Visible Devices,.....annually

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.
Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

The stobe condition effects any resident that passes this issue with the percentage of effect of feedback from state verification on people affected and those odds of probability.

Our contractor will be contacted to correct this issue before 9-12-11 per scheduling with the contractor. 9/12/11

The OEM " " rep has inspected this building quarterly per all documents on the Symplex fire suppression system and "another contractor" dose the smoke checks and may have the sensitivity results from this year. A 3rd fire extinguisher company " XXXX fire extinguisher" does fire extinguishers. All 3 companies will be contacted and one will be required to ensure that these tests are verified.

Follow up inspections will be performed through contractors and adjustment to the quality assurance program for follow up.
To complete by 9-12-2011
Page 6 9/12/11

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SALF	Continued From page 6	SALF		

F. Based on record review and staff interview the facility failed to ensure emergency battery lights were tested in 3 of 3 smoke compartments. The findings were:

Review of the emergency battery light testing records showed the facility had not conducted an annual 90 minute test since the building was opened in Aril 2002. On 7/12/11 at 2:05 PM the manager reported she was unaware of the annual testing requirement.

Reference:
4.6.12.1;
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 11/2 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.

G. Based on observation, record review, and staff interview the facility failed to ensure the kitchen hood fire suppression system was tested per the manufacturer's recommendations. The findings were:

Observation of the kitchen hood suppression system on 7/12/11 at 12:05 PM showed it was a "Guardian III Residential Range Top" system. At the time of observation, the manager reported the

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.
Resident rooms will be examined for non-compliance with this regulation and identified to the manager.

There was no effect on the residents because no deficiency was found with the lights upon inspection. This was simply a frequency and documentation issue.

The OEM fire Suppression contractor will be required to document the light test during one of their ~~quarterly exams.~~ ANNUAL TEST
Follow up inspections will be performed through contractors and adjustment to the quality assurance program for follow up
To complete by 9-12-2011 9/12/11

Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.
[redacted]

There was no effect on the residents
The range fire suppression was taken out of service at this location and there is no requirement that this is required at an ALF. It will stay at its present location with the option to put back into service at some point in the future. We will however inform employees and place an out of service tag on the unit.
To complete by 9-12-2011 9/12/11

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system was not inspected or tested. Review of the manufacturers owners manual showed there are weekly, monthly, annual, and 12 year testing requirements.

Reference:
OWNER'S MANUAL MODEL, G300-A, Wet Chemical Extinguisher Unit
THE GUARDIAN III, Stops Rangetop Fires Instantly
For Installation, Operation and Maintenance
UL FILE NO. EX 3940
Clean Up and Maintenance
Weekly, Sonic Receiver is Not Supervised. Perform signal test to insure system functions as required. See System Checkout on Page 16.
Monthly, check nozzles for visual signs of obstruction Check pressure gauge. If the needle points to the "recharge" or "overcharged" zone, contact an authorized Twenty First Century representative immediately for service.
Annually, inspect all components, including fire extinguisher unit, appliance nozzles, sensor, distribution assembly and shutoffs. Replace battery in the central processing unit control board and the " Optional Gas Sonic Shutoff " part #306-A unit annually from the date of installation.
Keep the Guardian III system free of cooking grease residue.
Every Twelve (12) years empty and hydrostatically test the fire extinguisher cylinder and flexible hose assembly to the marked pressure, per NFPA 17A. Replace the liquid chemical with new agent (P/N 79372) DO NOT combine chemicals.

Wyoming Department of Health Aging Division Rules

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Program Administration of Assisted Living Facilities Chapter 12
Effective December 12, 2007
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;
(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.

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SALF	Continued From page 9 This regulation was NOT MET as evidence by: --- H. Based on record review and staff interview, the facility failed to ensure the evacuation time was collected for 5 of 12 fire drills. The findings were: Review of the fire drill testing records showed the minutes and seconds it took to evacuate the building had not been collected for the fire drills held during July and September of 2010, and January, May and June of 2011. On 7/12/11 at 2:05 PM the manager reported she was aware of the aforementioned requirement. She was not able to explain why the times had not been collected. Reference: 32.7.3 Emergency Egress and Relocation Drills. Emergency egress and relocation drills shall be conducted not less than six times per year on a bimonthly basis, with not less than 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 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 credited in meeting the requirements of this Code for board and care facilities.	SALF	**Corrective Action for residents affected will be.. Posting of the survey and corrective actions taken.** [redacted] **There was no effect on the residents** **This was simply a documentation issue. All drills were conducted** **Follow up inspections will be performed through employee training and signed off, and adjustments made to the quality assurance program** [redacted] **To complete by 9-12-2011** 9/2/11 **Page 10**	