PRINTED: 03/15/2012
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
	ALF010	A. BUILDING _____ B. WING _____	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF EVANSTON	1949 WEST UINTA STREET 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 February 29, 2012 by the office of Healthcare Licensing and Surveys, (HLS). The facility was a single story fully sprinkled building of Type V (000) construction built in 2000. The building was equipped with a supervised automatic 13 R wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 16 licensed beds with a census of 6 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, 2000 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: --- A. Based on observation, record review, and staff	SALF	**The facility will add an inspection report that will be kept in the Quality Improvement Binder. This inspection report will be to inspect all resident doors to make sure that they are properly latching. This will done on a quarterly basis. The only instructions I had received from the Fire & Safety Inspector was to make sure that the two laundry room doors and the store room door were properly latching.** **The door for Room #1 was repaired on March 20, 2012, by our Maintenance Man.** **All other doors will be inspected.** **The Director will be responsible for compliance with this standard.** **Date of Completion: April 27, 2012**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Florence J Parks TITLE Director (X6) DATE 3-28-12

POC ACCEPTED W/ FLORENCE PARKS, DIRECTOR, ON 4/23/12.

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SALF	Continued From page 1 interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 2 smoke compartments. The findings were Observation of resident room #1 on 2/29/12 at 9:58 AM showed the latch for the corridor door was not able to insert the latch bolt into the strike plate. Review of the inspection records on 2/29/12 at 8:50 AM showed resident rooms were inspected on a monthly basis. Reference, 32.2.2.5.7, 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. --- B. Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 2 smoke compartments. Then findings were: Observation of the crawl space on 2/29/12 at 10:29 AM showed the space did not have sprinkler coverage. Further observation showed eight boxes of holiday decorations were stored in the area. On 3/5/12 at 2 PM the manager reported she was unaware items could not be stored in an un-sprinkled crawl space. 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.	SALF	**The facility will ensure that the basement will not be used for storage any longer.** **All items in the basement will be moved to our Storage Shed.** **The Director will be responsible for compliance with this Standard.** **Date of Completion: April 27, 2012**	

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SALF	Continued From page 2 (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. 32.2.3.2.3 Other hazardous areas shall be protected by one of the following: (1) An enclosure having a fire resistance rating of not less than 1/2 hour, with a self-closing or automatic-closing door in accordance with 7.2.1.8 that is equivalent to not less than 13/4-in. (4.4-cm) thick, solid-bonded wood core construction and is protected by an automatic fire detection system connected to the fire alarm system provided in 32.2.3.4.1 (2) Automatic sprinkler protection in accordance with 32.2.3.5, regardless of enclosure C. Based on observation and staff interview, the facility failed to ensure egress discharge pathways were unobstructed for 2 of 2 smoke compartments. The findings were: 1. Observation of the east patio on 2/29/12 at 9:41 AM showed the entire surface was covered with snow. The storm stopped at 11 AM the day before. On 3/5/12 at 2 PM the manager reported she was aware the egress pathway must be	SALF	**The facility will ensure that the snow will be removed from all egress pathways. The Director did call the snow removal contractor several times but could never reach them (this was at the time there was still snow on March 5, 2012).** **The Director finally contacted the contractor and they said they did not have anyone to come out that day due to illness. I told them this could not happen again and reconfirmed the importance of having the snow removed. The contractor assured me this would not happen again and if they could not make it out then they would contact the facility.** **The Director will be responsible for compliance with this standard.** **Date of Completion: March 21, 2012**	

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SALF	Continued From page 3 accessible at all times. She also reported that she was aware her snow removal contractor had not shown up, but could not explain why she had not called another contractor to remove the snow. 2. Observation of resident room #4 on 2/29/12 at 9:53 AM showed a wood lattice gate was installed in front of the corridor door. Further observation showed the gate brackets were screwed into the door frame. On 3/5/12 at 2 PM the manager was unaware fixed gates were prohibited from being installed in the egress pathway. Reference, 32.2.2.2 Primary Means of Escape. Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 32.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. --- D. Based on record review and staff interview, the facility failed to ensure emergency battery lights were tested during 2 of the past 12 months. The findings were: Review of the emergency battery light testing record showed the last monthly test was performed on 12/5/11. On 3/5/12 at 2 PM the manager reported the tests had been completed, but could not explain why the log had not been update for the past two months. Reference, 4.6.12.1, 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency	SALF	**The wood lattice gate that had the gate brackets screwed into the door frame for Room #4 will be removed.** **The Director will be responsible for compliance with this standard.** **Date of Completion: April 27, 2012**	

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SALF	Continued From page 4 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. Wyoming Department of Health Aging Division Rules Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4 Section 6. Furnishings, Building, Physical Plant (i) All drapery and curtains shall be flame retardant. This regulation was NOT MET as evidence by: E. Based on observation, record review, and staff interview, the facility failed to ensure window curtains were flame retardant in 2 of 2 smoke compartments. The findings were: Observation on 2/29/12 between 9:30 AM and 10 AM showed the window curtains in resident room #8, #6, and #5 did not have flame retardant documentation attached to them. Further observation showed the curtains were not stiff as would be expected if they had been treated with a fire retardant solution. Review of the flame retardant curtain log on 2/29/12 at 10:30 AM showed the log reported all curtains had been reviewed on a monthly basis. The log did not indicate any curtains had been treated with a flame retardant solution. On 3/5/12 at 2 PM the manager reported the curtains were inspected on a monthly basis. She confirmed that the curtains	SALF	**The facility will ensure that all testing of the emergency battery lights will be done on a 30 day basis. The inspections for 1/31/2012, 2/22/2012, and 3/29/2012 had not been recorded at the time the Fire & Safety Inspector was here. The Director had not updated the log and was an oversight. The last testing date of 3/29/2012, the emergency battery lights were left on for 120 minutes. Findings were that the batteries in the worklight in the hallway across from Room #5 were not working. These batteries will have to be replaced. Some of the other worklights that were completely out after 120 hours were the one in the living room, the one in the dining room, and hallway lights by Rooms #1, 3, 4 & 5. The test ran over the allotted time and I know that all the lights except the one in the hallway by Room #5 were working for 90 minutes.** **The Director will be responsible for compliance with this standard.** **Date of Completion: April 27, 2012**	

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SALF	Continued From page 5 felt stiff if treated with a flame retardant solution. She could not explain why the curtains did not feel stiff during survey. Reference, 32.7.5.1 New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with the provisions of 10.3.1. --- 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; (5.) Time required (minutes and seconds) to evacuate all residents (including staff) from the occupied areas to a point of assembly as defined	SALF	**The facility washes all the curtains on an annual basis as directed by the Fire & Safety Inspector. This is usually done in April of each new year. This information is recorded in the Quality Improvement Binder.** **All of the curtains were recently washed and the fire retardant spray and tags will be done. The resident in Room #5 changes out her curtains periodically and I forgot to spray them and retag. It has almost been a year so that is the only reason I can think of that the other curtains were not as stiff.** **The Director will be responsible for compliance with this standard.** **Date of Completion: April 27, 2012**	

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SALF	Continued From page 6 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: F. Based on record review and staff interview, the facility failed to ensure fire drills were held on each shift during 2 of the past 4 quarters. The findings were: Review of the fire drill record showed the first shift was from 7 AM to 3 PM, the second shift was from 3 PM to 11 PM and the third shift was from 11 PM to 7 AM. Further review showed a drill was not conducted on the third shift during the second quarter of 2011. Review also showed a drill was not conducted on the second shift during the third quarter of 2011. On 3/5/12 at 2 PM the manager reported she thought a drill had been conducted on each shift during each quarter. She could not explain why the drills had been missed. 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	SALF	**The facility does ensure that fire drills are done on a monthly basis. The reason the log sheet did not show that one drill is conducted each quarter on each shift was that I forgot to record on the log sheet the May 2012 fire drill. This has been corrected on the log sheet. Attached is the log sheet (See Attachment C & D).** **The Director will be responsible for compliance with this standard.** **Date of Completion: March 29, 2012**	

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SALF	Continued From page 7 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. 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 evidence by: G. Based on observation and staff interview, the facility failed to ensure portable space heaters were prohibited in 2 of 2 smoke compartments. The findings were: Observation on 2/29/12 between 9 AM and 10 AM showed a space heater was in use in resident rooms #11 and #4. On 2/28/12 at 3:30 PM the manager reported she was aware space heaters were prohibited, but they were occasionally used because the resident rooms were so cold.	SALF	**The director has now removed all space heaters from the building and will ensure that no space heaters are not used.** **The Director will be responsible for compliance with this standard.** **Date of Completion. March 5, 2012**	