PRINTED: 07/12/2011
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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
	ALF014	A. BUILDING _____ B. WING _____	06/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING WIND ASSISTED LIVING COMMUNITY	1072 NORTH 22ND STREET LARAMIE, WY 82072

(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 survey was conducted at your facility on June 28, 2011 by the Office of Healthcare Licensing and Surveys, (OHLS). The facility was a single story fully sprinkled building of Type V (111) construction built in 1998. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 75 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, 1994 Edition, unless otherwise noted. This regulation was NOT MET as evidence by: --- A. Based on observation and staff interview the	SALF	A. The facility will ensure that walls are smoke resistant in 4 of 4 compartments. This has been accomplished by: The 1 inch circular unsealed cable penetration has been sealed. The Director of Environmental Services will provide on-going monthly inspections of all 3 smoke compartments and ensure there are no non-sealed penetrations present. A log of this inspection will be maintained by the Director of Environmental Services. The Quality Improvement Committee will review results at quarterly meeting. B. The facility will ensure corridor wall are smoke resistant in 4 of 4 compartments. This has been accomplished by : The 1 ½ inch penetration in the ceiling above the north central exit has been sealed. The Director of Environmental Services will provide on-going	7/6/201

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tina Stone, Exec. Director TITLE (X6) DATE 7.21.11

STATE FORM 6899 2L241 If continuation sheet 1 of 7

POC Accepted w/ TA
ED., ON 8/04/11.

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Wyoming Dept of Health
AUG 02 2011
Office of Healthcare Licensing and Surveys

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SALF	Continued From page 1 facility failed to ensure walls were smoke resistant in 2 of 4 smoke compartments. The findings were: Observation of the activities office on 6/28/11 at 1:04 PM showed the room had a 1 inch circular unsealed cable penetration. At the time of observation the maintenance director reported he was aware of the separation requirement. He could not explain why the hole had not been identified and repaired during the quarterly inspections. 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.... --- B. Based on observation and staff interview, the facility failed to ensure corridor walls were smoke resistant in 1 of 4 smoke compartments. The findings were: Observation of the corridor system on 6/28/11 at 1:16 PM showed the ceiling above the north central exit had a 1 ½ inch circular penetration. Further review showed the hole was where a sprinkler had been removed after the last survey conducted on 6/01/10. At the time of observation the maintenance director could not explain why the hole had not been sealed after the sprinkler head was removed. Reference: 22-3.3.6.2 Sleeping rooms shall be separated from corridors and other common spaces by fire barriers complying with 322-3.3.6.3 through 22.3.3.6.6. 22-3.3.6.5 Walls and doors required by 21-3.3.6.1	SALF	monthly inspections of all 4 corridor smoke compartments and ensure there are no non-sealed penetrations present. A log of this inspection will be maintained by the Director of Environmental Services. The Quality Improvement Committee will review results at quarterly meeting.	7/1/2011

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SALF	Continued From page 2 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 2 of 6 smoke barrier walls were smoke resistant. The findings were: Observation on 6/28/11 between 2 PM and 2:30 PM showed the 200 hall smoke barrier wall and the smoke barrier near the nurses' station had unsealed pipe penetrations. The largest gap was a 2 foot square section. At the time of observation the maintenance director was aware of the separation requirement. He could not explain why the aforementioned penetrations were not identified and sealed during the annual inspection. Reference: 22-3.3.6.3 Fire barriers required by 22-3.3.6.1 or 22-3.3.6.2 shall have a fire resistance rating of not less than 20 minutes. Exception No. 1: In buildings protected throughout by an approved, automatic sprinkler system ...no fire resistance rating shall be required, but barriers shall resist the passage of smoke. D. Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 2 of 4 smoke compartments. The findings were: 1. Observation on 6/28/11 between 1:30 PM and 2 PM showed the main electrical room and the mechanical room had unsealed pipe	SALF C.	The facility will ensure that 6 of 6 smoke barrier walls are smoke resistant. This will be accomplished by: The Director of Environmental Services will seal the unsealed pipe penetrations in all areas. The Director of Environmental Services will provide on-going monthly inspections of all 6 smoke compartments and ensure there are no non-sealed pipe penetrations present. A log of this inspection will be maintained by the Director of Environmental Services. The Quality Improvement Committee will review results at quarterly meeting. 8/28/2011 D. The facility will ensure hazardous areas are separated from use areas in 4 of 4 smoke compartments. This was accomplished by: 1. The unsealed pipe penetrations mentioned were sealed.	

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SALF	Continued From page 3 penetrations. The largest gap was 1 ½ inch wider than the pipe running through the hole. At the time of observation the maintenance director reported he was aware of the separation requirement. He could not explain why the aforementioned penetrations were not identified and sealed during the quarterly inspection. – 2. Observation of the laundry room on 6/28/11 at 1:59 PM showed the corridor door was equipped with an automatic closing device. Further review showed the closure was not able to fully latch the door in the frame because the door was out of alignment. At the time of observation the maintenance director reported the door had recently been adjusted, but he was unsure how long it had been unable to latch. Reference: 22-2.3.2 Hazardous Areas. Any hazardous area shall be protected in accordance with the following: (a) 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 either: 1. An enclosure with a fire resistance rating of at least 1 hour ... 2. Automatic sprinkler protection, in accordance with 22-2.3.5, of the hazardous area and a separation that will resist the passage of smoke between the hazardous area and the sleeping area or primary escape route. Any door in such separation shall be self-closing or automatic-closing in accordance with 5-2.1.8. --- – E. Based on observation and staff interview, the facility failed to ensure alarm indicating devices/strobes were synchronized in 1 of 4	SALF	2. The hinges on the laundry room door have been replaced and the door now self closes with a full latch. The Director of Environmental Services will provide on-going monthly inspections of all 4 smoke compartments and ensure there are no non-sealed pipe penetrations present and that door closures are functioning properly. A log of this inspection will be maintained by the Director of Environmental Services. The Quality Improvement Committee will review results at quarterly meeting. 7/7/2011 E. The facility will ensure that alarm devices/strobes are synchronized in 4 of 4 compartments. This will be accomplished by: The alarm monitoring company will synchronize the strobes and test for synchronization during quarterly visits. The alarm company will provide documentation and this	

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SALF	Continued From page 4 smoke compartments. The findings were: Observation of the north hall on 6/28/11 at 3:27 PM showed the three alarm indicating device/strobes were all in the same field of view and they were not synchronized. Observation of the strobes through the fire drill showed the flashing was not synchronized then gradually became synchronized, then again flashed independently. At the time of observation the maintenance director reported he was aware of the aforementioned requirement. He reported the system had been reviewed after last year's survey and he assumed the problem had been corrected. He confirmed the strobes were not monitored to ensure compliance. Reference: 22-2.3.4.1 Fire Alarm Systems. A manual fire alarm system shall be provided in accordance with Section 7-6. 7-6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with applicable requirements of ...NFPA 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code, 1993 Edition. 4-4.4.1.1 Strobe Spacing Shall be: 4. More than two in the same field of view shall be synchronized. --- F. Based on observation and staff interview, the facility failed to ensure fire extinguishers were properly posted in 1 of 4 smoke compartments. The findings were: Observation of the kitchen K type fire extinguisher on 6/28/11 at 2:06 PM showed there was no	SALF	documentation will be maintained at the facility. The Director of Environmental Services and the Administrator will ensure this is a part of the quarterly inspections. The Quality Improvement Committee will review results at quarterly meeting. F. The facility will ensure that fire extinguishers are properly posted in 4 of 4 compartments. This will be accomplished by: The Director of Environmental Services will order the proper signage for the kitchen K type fire extinguisher. (A temporary sign is in place) The Director of Environmental Services will provide on-going monthly inspections of fire extinguishers and ensure proper signage is posted. A log of this	8/28/2011

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SALF	Continued From page 5 signage that instructed the activation of the hood suppression system prior to using the extinguisher. At the time of observation the maintenance director reported he was not aware of the aforementioned requirement. Reference: 22-3.3.5.3 Portable Fire Extinguishers. Portable fire extinguishers in accordance with 7-7.4.1 shall be provided near hazardous areas. 7-7.4.1 ....Portable fire extinguishers shall be installed in accordance with NFPA 10, Standard for the Installation of Portable Fire Extinguishers. NFPA 10 Standard for the Installation of Portable Fire Extinguishers, 1990 Edition. 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states the fire protection system shall be activated prior to using the fire extinguisher. G. Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 4 smoke compartments. The findings were: 1. Observation of the electrical system on 6/28/11 between 1:30 PM and 2 PM showed the telephone in resident room #201, and the refrigerator in resident room #116, were plugged into 3-way electrical adapters. At the time of observation the maintenance director reported he was aware electrical adapters were prohibited. He could not explain why the aforementioned adapters had not been noticed and removed during the quarterly inspections. 2. Observation of the electrical system on 6/28/11 at 2:03 PM showed the pop machine and	SALF	inspection will be maintained by the Director of Environmental Services. The Quality Improvement Committee will review results at quarterly meeting. G. The facility will ensure that temporary electrical wiring will not replace permanent fixed wiring in 4 of 4 smoke compartments. This will be accomplished by: 1. The 3-way adapters in room #201 and #116 were replaced with surge protectors. 2. Estimates have been received for the installation of raceway and receptacle for vending machine. This will be installed and completed. The Director of Environmental Services will provide on-going monthly inspections of all 4 smoke compartments and ensure there is no temporary electrical wiring present. A log of this inspection will be	8/28/2011

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SALF	Continued From page 6 refrigerator in the break room were plugged into a surge protector. Further review showed the cord to the surge protector ran through a 2 inch hole in the wall and plugged into an outlet in the dining room. At the time of observation the maintenance director reported he was not aware power cords could not be run through walls. Reference: 22-3.6.1 Utilities. Utilities shall comply with provisions of Section 7-1. 7-1.2 Electrical wiring and equipment installed shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, National Electrical Code, 1993 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	documentation will be maintained at the facility. The Director of Environmental Services and the Administrator will ensure this is a part of the quarterly inspections. The Quality Improvement Committee will review results at quarterly meeting. Spring Wind will submit plans for the electrical modification to the WDH - Office of Healthcare Engineering Department. The plans will be fulfilled once the plan has been accepted. The facility will ensure that fire extinguishers are properly posted in 4 of 5 compartments. This will be accomplished by: The Director of Environmental Services will order the proper signage for the kitchen K type fire extinguisher. (A temporary sign is in	8/28/2011

p 7 Addendum
Send to J. Jensen
Faxed 8/9/11 JB