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
	ALF023	A. BUILDING _____ B. WING _____	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE RETIREMENT COMMUNITY OF GIL	921 MOUNTAIN MEADOW LANE GILLETTE, WY 82716

(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		

An initial Health and Life Safety Code survey was conducted at your facility by the Office of Healthcare Licensing and Surveys (OHLS) on 04/08/11. The survey revealed the facility was out of compliance with the Rules and Regulations for Program Administration (Chapter 12) and for Licensure (Chapter 4) of Assisted Living Facilities (ALF).

Wyoming Department of Health Aging Division Rules For Program Administration of Assisted Living Facilities

Chapter 4 Section 10 Life Safety and Electrical Safety
This REGULATION was not met as evidenced by:
1. Based on record review and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 25. The findings were:
Record review revealed the facility ' s sprinkler system consisted of both dry and wet loops. The system was last tested including the main drain test at the time of initial facility opening on 3/8/10 and had not been inspected since. Interview with the facility administrator on 04/08/11 at 9:48 AM confirmed the sprinkler system had not been tested since the facility opened.

Reference NFPA 101 Life Safety Code, 1994 Edition
" NFPA 101, Chapter 32 Referenced Publications: "

Plan of Correction

Chapter 4 Section 10
Life Safety and Electrical Safety

Primrose will maintain the installed sprinkler system in accordance with NFPA 25.
Inspection, Testing and Maintenance of the Water-based Fire Protection System was completed on 04/18/11.

The system is scheduled quarterly for inspection: The main drains at each water based system riser will be tested to determine whether there has been a change in the condition of the water supply piping and/or control valves.

Waterflow alarms will also be tested with each inspection quarterly.

A form will be created to record date of inspections, result of testing and maintenance required and completed. Form will be completed by 05/12/11.

Monitoring of system information will be review quarterly by the Quality and Safety Assurance Team.

TITLE (X6) DATE

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

RECEIVED
Wyoming Dept of Health
MAY 02 2011
Office of Healthcare Licensing and Surveys

This Initial Health and LSC PoC accepted with agreed to changes between Administrator (David Dodge) and Tony Mullins on 5/14/11.

5/14/11

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SALF	Continued From page 1 " NFPA 25, Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition. " " 9-2.6* Main Drain Test. A main drain test shall be conducted quarterly at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. " " 9-2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with manufacturer's instructions. " 2. Based on observation, record review and staff interview, the facility failed to provide adequate fire protection in the kitchen in accordance with NFPA 96. The findings were: Observation on 4/8/11 at 8:48 AM revealed a modern kitchen with commercial cooking equipment capable of preparing meals for in excess of 50 residents (ALF licensure). In addition, observation revealed an ANSUL fire suppression system installed over the cooking surface. Also observed was an " ABC " type of portable fire extinguisher attached to the wall in close proximity to the cooking equipment. Record review revealed the kitchen fire suppression system satisfied all UL-300 requirements. Interview with the maintenance manager at the time of the observation revealed he did not know why the fire extinguisher company attached an " ABC " type of portable fire extinguisher instead of a " K " type extenguisher. Reference NFPA 101 Life Safety Code, 2000 Edition " NFPA 96, Standard for Ventilation, Control and Fire Protection of Commercial Cooking Operations. " 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in	SALF	**LIFE SAFETY CODE : NFPA 101** **NFPA 96, Standard for Ventilation, Control and Fire Protection of Commercial Cooking Operations 9.2.3** **The requirement for protection of commercial cooking areas has been met by the placement of a 'K-type fire extinguisher in the kitchen: 04/09/11.**	

5/16/11

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SALF	Continued From page 2 accordance with the standards for ventilation, control and fire protection of commercial cooking operations which require that new fire protection systems meet the requirements of UL 300 ' s fire testing for commercial extinguishing systems for protection of commercial cooking areas that require the use of a K-type fire extinguisher. " Chapter 12 Section 7. Assisted Living Facility (ALF) Core Services. (b) Resident Assessment and Services (i) The completion of the ALF 102 (I) The ALF 102 is only valid if completed within forty-five (45) days prior to admission and there is no change in the resident ' s condition. This REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete the ALF 102 in a timely manner for 2 of 3 sample residents (#1, #3). The findings were: Review of the medical records for residents #1 and #3 showed the following assessment concerns: Resident #1 was admitted on 10/1/10, but the initial ALF 102 was not completed until 11/3/10 (33 days after admission). Resident #3 was admitted on 9/29/10, but the initial ALF 102 was not completed until 11/3/10 (35 days after admission). Interview with the director of nursing services (DNS) on 4/8/11 at 10:45 AM confirmed she was aware the facility should complete the initial ALF 102 prior to admission for each	SALF	**CHAPTER 12** **SECTION7** **Assisted Living Facility (ALF) Core Services: "completion of the ALF 102 within 45 days prior to admission and no change in condition" regulation deficiency was identified on 10/29/10: corrective measures were implemented 10/31/10.** **At that time Residents were assessed according to the requirement and to date correct implementation of the required use of the ALF 102 is in place.** **ALF 102 will be placed on admission checklist for completion. Procedure will be monitored by QA Quaterly.** **SECTION 7** **Assisted Living Facility (ALF) Core Services.** **(b) Resident Assessment and Services** **(vi) Resident assistance plan.** **AL Wizard computer generated form "INDIVIDUAL SERVICE PLAN" will be signed by facility manager and resident or resident family.** **Facility Manager will have completed signing all current INDIVIDUAL SERVICE PLANS by 5.3.11.**	

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SALF	Continued From page 3 resident. Section 7. Assisted Living Facility (ALF) Core Services. (b) Resident Assessment and Services (vi) Resident assistance plan. (B) Each facility shall construct its own forms for such plans, which at a minimum shall contain documentation of the following: (VII) Dated signature of the RN, the facility manager, and the resident or the resident ' s responsible party. This REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure each required person signed the resident assistance plan for 3 of 3 sample residents (#1, #2, #3). The findings were: Review of the medical records for the three sample residents showed the facility manager failed to sign the resident assistance plans. The DNS and resident signed in each case. During an interview with the facility manager on 4/8/11 at 10:45 AM, he stated that he had not signed the assistance plans because he was unaware of that requirement. Section 7. Assisted Living Facility (ALF) Core Services. (i) Adult Protection (ii) The facility must adhere to written policies and procedures that prohibit the abuse of any resident. (iii) The facility is responsible to ensure all	SALF	**As INDIVIDUAL SERVICE PLANS are developed, Facility Manager will review and sign prior to resident/resident family signature.** **A checklist will be implemented with nightly chart checks by Night License Nurse to review signature compliance.** **Procedure will be monitored by QA quarterly.** **SECTION 7** **Assisted Living Facility (ALF) Core Services.** **(i) Adult Protection** **(iii)The facility is responsible to ensure all allegations of abuse are investigated expediently.** **Wyoming State specific abuse investigation procedures have been incorporated into Primrose Assisted Living facility Adult Protection Policy and Procedure as of 4/28/11.**	

5/16/11

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SALF	Continued From page 4 allegations of abuse are investigated expediently. (B) The facility must ensure that authorities are contacted if there is an allegation of abuse, neglect or exploitation. These additional authorities may include the Wyoming State Board of Nursing, Office of Healthcare Licensing and Survey, and the State Long Term Care Ombudsman. This REGULATION was not met as evidenced by: Based on review of the facility policies and procedures and staff interview, the facility failed to establish a Wyoming state specific abuse investigation procedure. The findings were: Review of facility abuse policy revealed an excellent discussion of abuse prepared by Thomco Insurance Enterprises Inc. The discussion covered all relevant topics of abuse including types, identifying, causes, etc. The policy went on to further state " anyone who knows of a client experiencing abuse or neglect is obligated to notify the proper authorities. Reporting procedures vary by state. Every state has an office or department that deals with abuse and neglect. " Further review of facility documentation, however, did not describe Wyoming-specific procedures to be followed by the facility in the event of an allegation of abuse. Interview with the facility administrator on 04/08/11 at 9:48 AM verified the facility ' s procedurewas supposed to address the specifics (how, when, to whom, etc) of abuse reporting in the event an allegation of abuse should ever occurred. Section 7. Assisted Living Facility (ALF) Core Services. (o) Evacuation Capability, Emergency	SALF	**Specifically, Wyoming Office of Healthcare Licensing and Survey Facility Incident Report Form and Adult Protective Services information have been added to Primrose Decision Tree for Event Reporting.** **All Assisted Living Staff will be educated on revised procedures on 5/12/11.** **Compliance with Primrose Assisted Living Facility Adult Protection Policy and Procedure will be monitored by review of Events through the QA Committee.** **SECTION 7** **Assisted Living Facility (ALF) Core Services** **(o) Evacuation Capability Emergency Procedures and Fire Safety** **The Fire Emergency Plan Instruction for each resident will be completed on the first day of admission.** **Resident training for Fire Emergency Plan has been separated from the Orientation checklist as of 4/28/11.**	

5/16/11

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SALF	Continued From page 5 Procedures, and Fire Safety. (iii) Fire Safety (D) Resident training for the fire emergency plan shall be in accordance with the Life Safety Code Operating Features sections. (I) On the first day of admission, each resident shall be instructed in the proper action of the fire emergency plan, including the location of all the exits. A record of this instruction shall be in each resident file. This REQUIREMENT was not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 3 of 3 sample residents (#1, #2, #3) received prompt instruction regarding the facility ' s fire emergency plan. The findings were: Review of the medical records for the three sample residents showed the following safety concerns: Resident #1 was admitted on 10/1/10, but medical record review showed the facility failed to instruct the resident concerning the facility ' s fire emergency plan. The form that included the fire drill instruction was left blank for that area, and the resident had not signed the form. Resident #2 was admitted on 10/29/10, but the facility failed to instruct the resident on the facility ' s fire emergency plan until 11/10/10 (twelve days after admission). Resident #3 was admitted on 9/29/10, but the facility failed to instruct the resident concerning the facility ' s fire emergency plan. The form that included the fire drill instruction was left blank for that area, and the form was not signed until 11/11/10 (forty-three days after admission). Interview with the director of nursing services on 4/8/11 at 10:45 AM, verified she was aware that the facility	SALF	**The Safety Committee is developing an Instructional Guide for Fire Emergency and Evacuation specific to each resident's apartment location. Guide will be completed by 5/3/11.** **Instructional Guide will include;** ***Location of all Exits** ***Area of Refuge** *** First Responder Locator button.** ***Apartment specific emergency notification alarms /lights equipment.** ***Evacuation Plan** ***Evacuation Route** ***Fire Drill Instruction** **Documentation of Admission Emergency Plan Instruction Guide will be a checklist signed by the resident on the first day of admission.** **All Fire Emergency Plan Education for current residents will be completed by 5/19/11.** Progress will be monitored and brought to the QA committee quarterly by the DON or designee. 5/3/11	

5/16/11

PRINTED: 04/22/2011
FORM APPROVED

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SALF	Continued From page 6 should instruct each resident concerning the facility ' s fire emergency plan upon admission.	SALF		