Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF27	A. BUILDING: _____ B. WING _____	11/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONDELL HEIGHTS RETIREMENT COMMUNITY	106 E MAIN STREET NEWCASTLE, WY 82701

(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		

RECEIVED
WY Dept of Health
DEC 31 2013
Healthcare Licensing and Surveys

A Life Safety Code survey was conducted at your facility on November 18, 2013 by the office of Healthcare Licensing and Surveys, (HLS).

The facility was a single story, fully-sprinklered building of Type II (111) construction built in 1949. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and a zoned fire alarm system. The facility had a capacity of 23 licensed beds with a census of 19 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, 1994 Edition, unless otherwise noted.

This regulation was NOT MET as evidence by:

A. Based on observation and facility staff interview, the facility failed to ensure hazardous

PoC Accepted w/ Diane Bates Hudson, Director on 1/07/14.

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SALF	Continued From page 1 areas were separated from use areas in 2 of 4 smoke compartments. The findings were: 1. Observation of the two basement stairwell doors on 11/18/13 at 2:44 PM showed both door were equipped self-closing devices. Further observation showed both doors were impeded from closing by rubber wedges forced under the doors. The entire basement was used as a storage area. At the time of the observation, the maintenance director reported he was unaware the aforementioned doors could not be wedged open. 2. Observation of the pantry on 11/18/13 at 3:21 PM showed 15 cardboard boxes storing dry foods. Further observation showed the corridor door was not equipped with a self-closing device. At the time of the observation, the maintenance director reported he was unaware storeroom corridor doors were required to have self-closing devices. Reference NFPA 101, 1994 Edition; 22-3.3.6.6 Doors in walls required by 22-3.3.6.1 and 22-3.3.6.2 shall be self-closing or automatic-closing in accordance with 5-2.1.8 doors in walls separating sleeping rooms from corridors shall be automatic-closing in accordance with 5-2.1.8.... ...Exception No. 2: In buildings protected throughout by an approved, automatic sprinkler system installed in accordance with 22-3.3.5, doors, other than doors to hazardous areas, vertical openings, and exit enclosures, shall not be required to be self-closing or automatic-closing. B. Based on observation and facility staff interview, the facility failed to ensure egress	SALF	**Chapter 4, Sec 10 Life Safety and Electrical Safety. Hazardous Areas** **A. The facility will ensure that hazardous areas will be separated from use areas by implementing the following actions:** 1. **The owners will develop specific training to be added to the routine staff training regarding keeping hazardous areas separate from use areas.** 2. **This training will be conducted by the Maintenance Director.** 3. **A self closing device will be installed on the pantry door.** 1/18/14	

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SALF	Continued From page 2 corridors were maintained unobstructed and failed to ensure egress pathways were maintained with an elevation change of less than ¼ inch in 1 of 4 smoke compartments. The findings were: 1. Observation of the resident corridor on 11/18/13 at 2:21 PM showed two book shelves that measured 6 feet tall were not restrained. Further observation showed 3 light weight chairs were not restrained. The aforementioned furnishings could fall into the corridor and block the egress pathway. At the time of the observation, the maintenance director reported he was unaware furnishings in corridors were required to be restrained. 2. Observation of the smoke barrier threshold on 11/18/13 at 2:32 PM showed five tiles were cracked. Further observation showed the cracked tiles caused a 3/8 of an inch elevation change. At the time of the observation, the maintenance director reported the tiles were damaged three months earlier. He reported the tiles were not repaired because he was looking for the best repair solution. Reference NFPA 101, 1994 Edition, 22-3.2.5.1; 5-2.1.3.3 The elevation of the floor surfaces on both sides of a door shall not vary more than ½ in. The elevation shall be maintained on both sides of the door way for a distance at least equal to the width of the widest leaf. Thresholds at doorways shall not exceed ½ in. in height. Raised thresholds and floor level changes greater than ¼ in. at doorways shall be beveled with a slope not steeper than 1 in 2. 5-6.1.1 Exits shall be located and exit access shall be arranged that exits are readily accessible at all times.	SALF	B. The facility will ensure that egress corridors will be maintained unobstructed with an elevation change of less than ¼ inch. The maintenance department will: 1. Secure or remove any obstructions in egress corridors. 2. Replace and repair the smoke barrier threshold in the main hallway.	1/18/13 1/18/14

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SALF	Continued From page 3 5-5.1.2 Where exits are not immediately accessible from an open floor area, safe and continuous passageways, aisles, or corridors leading directly to every exit shall be maintained and shall be arranged to provide access for each occupant to at least two exits by separate ways of travel. C. Based on record review and facility staff interview, the facility failed to ensure 1 of 7 fire alarm system components was tested. The findings were: Review of the fire alarm system testing records showed the bi-annual smoke detector sensitivity test was last tested on 2/17/11, more than two years ago. On 11/18/13 at 5:15 PM, the maintenance director could not explain why the sensitivity test had not been conducted within the past two years. Reference NFPA 101, 1994 Edition, 22-3.3.4.8, NFPA 72, 1993 Edition; Table 7-3.2 Testing Frequencies. 15. Initiating Devices i. Smoke Detectors- Sensitivity, ... bi-annually D. Based on record review and facility staff interview, the facility failed to ensure 2 of 3 emergency generator tests were performed as required. The findings were: Review of the emergency generator testing records showed the egress lights were supplied with power by the generator. Further review showed the last monthly full load transfer test was performed on 10/15/13. The transfer time from normal power to emergency power had not been collected in the past year. On 11/18/13 at 5:15	SALF	C. Testing of Fire Alarm System components The facility will ensure that all 7 fire alarm system components are tested as required by NFPA 101: 1. The owners will add the bi-annual smoke detector sensitivity test to the Master List of required maintenance activities. 1/18/13 D. Required Emergency Generator tests as defined in NFPA 101. The facility will ensure that transfer times are collected when transferring from normal power to emergency power by: 1. Training maintenance staff regarding the need to document during the regular generator test the transfer time on the log. 2. The owners will review the log for evidence that the transfer time is being logged. 1/18/14 1/18/13	

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SALF	Continued From page 4 PM, the maintenance director reported he was unaware the transfer time were required to be collected monthly. Reference NFPA 101, 1994 Edition, 22-3.2.9; 5-9.1.2 ... Where emergency lighting is provided by a prime mover-operated electrical generator, a delay of not more than 10-seconds shall be permitted. E. Based on observation and facility staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 3 of 4 smoke compartments. The findings were: Observation of the electrical system on 11/18/13 between 2 PM and 5:30 PM showed the following locations had prohibited electrical adapters in use: a. Resident room #1 had a lamp plugged into an extension cord. b. Resident room #16 had a refrigerator plugged into an extension cord. c. Maintenance directors office computer was plugged into two surge protectors in-line. On 11/18/13 at 2:15 PM, the maintenance director could not explain why the aforementioned electrical adapters had not been noticed and removed during the monthly safety inspections. Reference NFPA 101, 1994 Edition, 22-3.6.1, 7-1.2, NFPA 70, 1993; 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	SALF	E. Electrical System – ensure temporary electrical wiring does not replace permanent fixed wiring The facility will ensure that temporary electrical wiring does not replace permanent fixed wiring by: 1. Providing in-service training to all employees regarding the dangers and code compliance issues regarding the use of extension cords. 2. Continue to check for use in resident rooms and document monthly. 3. Add all other rooms to the monthly check for such inappropriate electrical devices. 4. Review all monthly inspections by management. 1/18/14	1/18/13

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SALF	Continued From page 5 similar openings (4) Where attached to building surfaces 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. (i) Evacuation Capability. (A) The evacuation capability rating for the group of residents, as defined by the Life Safety Code, in accordance with licensure rules, shall meet prompt or slow for facilities with nine (9) or more residents, and the rating shall meet prompt for facilities of eight (8) or fewer residents. The facility shall be responsible for maintaining evacuation capability ratings by timed fire exit drills. (I) Exception shall be a facility where the construction meets the impractical evacuation capability rating. (B) Evacuation Capability Ratings: (I) Prompt - maximum of three (3) minutes (II) Slow - between three (3) and thirteen (13) minutes (III) Impractical - more than thirteen (13) minutes (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.	SALF		

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SALF	Continued From page 6 (l) 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. This regulation was NOT MET as evidence by: F. Based on record review and facility staff interview, the facility failed to ensure fire drills were held on 1 of 3 shifts on a quarterly basis. The findings were: Review of the fire drill records showed the third shift occurred between 9 PM and 6AM. Further review showed a fire drill had not been conducted on the third shift during the first and second quarters of 2013. On 11/18/13 at 5:15 AM, the maintenance director could not explain why the aforementioned fire drills had not been	SALF		

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SALF	Continued From page 7 conducted. Reference NFPA 101, 1994 Edition, 22-3.5, 31-7; 31-7.3 Fire Exit Drills. Fire exits drills shall be conducted at least six times per year on a bi-monthly basis with a minimum of 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 the experience in egressing through all exits and means of escape required by the Code. Exits and means of escape not used in any fire drill shall not be credited in meeting the requirements of this Code for board and care facilities. Wyoming Department of Health, Rules and Regulations for Licensure of Assisted Living Facilities Chapter 4 Section 9. Construction/remodeling. Department of Health Chapter III, Construction Rules for Health Facilities apply. This regulation was NOT MET as evidence by: G. Based on observation and facility staff interview, the facility failed to ensure the replacement of fire safety system components had plan approval from the Wyoming Department of Health. The findings were: Observation of the fire alarm control panel on 11/18/13 at 3:52 PM showed the panel was replaced in October 2013 with a Fire Lite MS	SALF	F. Evacuation Capability, Emergency Procedures and Fire Safety, Evacuation Drills The facility will ensure that there are Evacuation Drills on a monthly basis with a minimum of one drill conducted each quarter on each shift by: 1. In-service training for all staff on this requirement. 2. Conducting and documenting the timed exit drills and reviewing those drill times by reviewing the Master List. 1/18/13 1/18/14	

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SALF	Continued From page 8 10UD panel. Further observation showed only the panel was replaced and all other fire alarm system components were utilized. At the time of the observation, the owner reported he was unaware construction and safety system replacement required plan approval from the Wyoming Department of Health as outlined in the Chapter 3 Construction Rules & Regulations for Health Care Facilities.	SALF	G. Chapter 3 Construction Rules and Regulations for Healthcare Facilities The facility will ensure that changes of fire safety system components have plan approval from the Wyoming Department of Health by: 1. Providing in-service training to relevant staff regarding the need to seek Health Department approval for significant changes in the fire safety system. 2. FACILITY WILL SUBMIT PLANS FOR NEW FIRE ALARM PANEL TO ENGINEERING DEPT. OFFICE OF HEALTHCARE LICENSING & SURVEYS TO ENSURE COMPLIANCE WITH FIRE SAFETY CODES.	1/18/14