STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
	WY9055	A. BUILDING: _____ B. WING _____	05/09/202

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN PLAZA ASSISTED LIVING	536 EAST 20TH AVENUE TORRINGTON, WY 82240

(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)	(X COMP DAT
S 000	General Comments A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 05/09/2023. The facility was a fully sprinklered single story buildings of Type V (000) construction with plan approval of 2020. The building was equipped with a supervised wet sprinkler system with dry branch, and an addressable fire alarm system. The facility had a capacity of 45 licensed beds with a census of 26 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 and Regulations for Healthcare Facilities applies (II) Assisted Living Facilities in operation prior to the effective date of those rules shall meet the Life Safety Code of 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 2006 Edition, unless otherwise noted.	S 000		
S8017	NFPA Life Safety - Nfpa Det, Alarm & Comm Systems NFPA 101 Detection, Alarm and Communication Systems This State Rule and Regulation is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2006 NFPA 101, Life Safety	S8017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brian Small, PM Executive Director 06/02/2023

Spoke to Brian Small, Executive Director, by phone on 6/20/2023 @ 8:45 AM and Advised him of the Plan of Corrections Acceptance. # 41673

Healthcare Licensing and Surveys

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S8017	Continued From page 1 Code and the 2002 NFPA 72, National Fire Alarm Code. Failure to maintain fire detection systems as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous requirements for the fire alarm system. The findings were: Observation on 05/09/2023 at 11:47 AM at the fire annunciator panel revealed that the Underwriter's Laboratory (UL) certification for the fire alarm was expired. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 NFPA Sections 32.3.3.4.1; 9.6.1.3 2002 NFPA 72 Section 8.2.4.1.2 2. Based on document review and staff interview, the facility failed to have a fire watch plan in accordance with the 2012 NFPA 101, Life Safety Code. Failure to create a fire watch plan as required may lead to injury or death during an emergency. The deficiencies affected the entire facility. The findings were: Document review and staff interview on 05/09/2023 at 2:45 PM revealed the facility did not have a procedure to activate a fire watch in the event the fire alarm was out of service. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement.	S8017		

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S8017	Continued From page 2 Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 NFPA 101, Section 32.3.3.4.1, 9.6.1.6	S8017		
S8018	NFPA Life Safety - Nfpa Extinguishment Req NFPA 101 Extinguishment Requirements This State Rule and Regulation is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the 2006 NFPA 101, Life Safety Code and the 2002 NFPA 25, Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems. The failure to maintain sprinkler systems as required could result in injury or death during an emergency. The deficiency affected one of numerous storage areas throughout the facility. The findings were: Observation on 05/09/2023 at 2:23 PM in the kitchen storage revealed there was storage stacked within the 18" height clearance to the sprinkler head, which results in an obstruction to the dispersion pattern of the affected sprinkler. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 NFPA 101, Sections: 32.3.3.5.1; 9.7.5	S8018		

Healthcare Licensing and Surveys

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S8018	Continued From page 3 2002 NFPA 25, Section 5.2.1.2 2. Based on document review and staff interview, the facility failed to have a fire watch plan in accordance with the 2012 NFPA 101, Life Safety Code. Failure to create a fire watch plan as required may lead to injury or death during an emergency. The deficiencies affected the entire facility. The findings were: Document review and staff interview on 05/09/2023 at 2:45 PM revealed that the facility did not have a procedure to activate a fire watch in the event the fire sprinkler system was out of service. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 NFPA 101, Section 32.3.3.5.1, 9.7.6.1	S8018		
S8019	NFPA Life Safety - Nfpa Portable Fire Extinguisher NFPA 101 Portable Fire Extinguishers This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to provide access to fire extinguishers in accordance with the 2002 NFPA 10, Standard for Portable Fire Extinguishers and	S8019		

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S8019	Continued From page 4 the 2006 NFPA 101, Life Safety Code. Failure to provide access to a fire extinguisher as required may lead to injury or death during an emergency. The deficiencies affected two (2) of numerous fire extinguishers in the facility. The findings were: Observation on 05/09/23 at 2:20 PM in the kitchen found that both of the fire extinguishers present had not been inspected for the months of March and April of 2023. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 2006 NFPA 101: Section 32.3.3.5.6, 9.7.4.1 2010 NFPA 10: Section 6.2.1	S8019		
S8025	NFPA Life Safety - Nfpa Emergency Plan NFPA 101 Emergency Plan This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the WDH Chapter 3 Construction Rules and Regulations for Healthcare Facilities, WDH Chapter 12 Program Administration of Assisted Living Facilities, and the 2006 NFPA 101 Life Safety Code. Failure to conduct fire drills as required could result in injury or death during an emergency. The findings were:	S8025		

Healthcare Licensing and Surveys

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S8025	Continued From page 5 Document review on 05/09/2023 at 2:58 PM revealed the facility had not completed a sufficient number of 2nd shift fire drills, having no drills for the 2nd shift in the 3rd and 4th quarters of 2022. Additionally, the facility failed to perform two of the drills during the night while residents were asleep. Interview with the facility administrator at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 NFPA 101 Section 32.7.3.1 WDH CH 12 Section 7 (o)(iii)(E)	S8025		
S8030	NFPA Life Safety - Nfpa Miscellaneous NFPA 101 Miscellaneous This State Rule and Regulation is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to provide a resident room without oxygen storage in accordance with NFPA 99, Standard for Health Care Facilities. The failure to provide a resident room free of oxygen storage could result in injury or death in an emergency. The deficiency affected one (1) of thirty (30) resident rooms in the facility. The findings were: Observation on 05/09/2023 at 2:05 PM in Rm 609 revealed that the resident had less than 300 cubic feet of small oxygen cylinders stored in their room, ranging in cylinder size A to E. Several of the cylinders were placed on the floor,	S8030		

Healthcare Licensing and Surveys

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S8030	Continued From page 6 freestanding. Staff interview revealed that the resident self-filled the cylinders for personal use. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. Ref. 2005 NFPA 99 Section 9.4.3.2, 9.7.2.3(11), 9.4.3.4, 9.4.4.1 2. Based on observation and staff interview, the facility failed to provide a placard at fire extinguishers in accordance with the 2006 NFPA 101, Life Safety Code, and the 2001 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. The failure to provide instructional placards at fire extinguishers may lead to inapproprate use by staff, which may lead to injury or death during an emergency. The deficiency affected two (2) of two (2) fire extinguishers in the kitchen. The findings were: Observation on 05/09/2023 at 2:28 PM in the kitchen revealed that placards were not conspicuously placed near the portable fire extinguishers stating the fire protection system shall be actuated prior to using the fire extinguisher. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	S8030		

Healthcare Licensing and Surveys

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S8030	Continued From page 7 Ref: 2006 NFPA 101 Sections: 32.3.3.8, 9.2.3 2001 NFPA 96 Section: 10.2.2	S8030		
S8999	State Miscellaneous Life Safety State Miscellaneous This STANDARD is not met as evidenced by: 1. Based on observation and staff interview, the facility failed to keep the boiler room free of combustible storage in accordance with the WDH Chapter 3 Construction Riles and Regulations for Healthcare Facilities and the 2006 International Fire Code. Failure to keep boiler room free of combustible storage as required could contribute to fire, which may result in injury or death. The findings were: Observation on 05/09/23 at 11:48 AM in the boiler room revealed the facility had stored a large pile of paint cans in the southeast corner of the room. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 International Fire Code 315.2.3 2. Based on observation and staff interview, the facility failed to keep resident door self-closing devices operable in accordance with the WDH Chapter 3 Construction Rules and Regulations for Healthcare Facilities, and the 2006 International Building Code. Failure to keep resident door self-closing devices operable as required could	S8999		

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S8999	Continued From page 8 lead to injury or death during an emergency. The findings were: Observation on 05/09/23 at 01:16 PM, at room 522, revealed the resident room door had been provided with a self-closing device, but that the connecting arms and closing mechanism had been removed. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2006 International Building Code 715.4.7 3. Based on observation and staff interview, the facility failed to provide under sink protection in accordance with the 2006 International Building Code and the ANSI A117.1-2003. Failure to provide under sink protection as required could lead to scalding due to contact with high temperature piping. The findings were: Observation on 05/09/23 at 2:25 PM in the kitchen revealed that the kitchen hand wash lavatories failed to have protection against contact on supply and drain pipes. Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	S8999		

Healthcare Licensing and Surveys

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S8999	Continued From page 9 REF: 2006 International Building Code Section 1101.2 ICC/ANSI A117.1-2003 Section 606.6	S8999		

Evergreen Plaza

Life Safety Survey

Survey ending 5/09/2023

This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.

S8017

1. A new certificate was obtained and posted near the fire annunciator panel. A fire watch plan has been developed.
2. There is potential for all residents and staff to be adversely affected by a failed fire alarm system and the absence of a fire watch plan.
3. The Maintenance Director has added the certificate expiration date to the Preventive Maintenance plan. Staff were educated on how to activate and implement a fire watch system and when this would be necessary. The fire watch system was added to the initial orientation of staff. The Maintenance Director will conduct regular training of staff on the fire watch system.
4. The Executive Director is responsible for ensuring the safety of residents and staff and will continue to monitor certificates of compliance and related materials. The Executive Director will also ensure that policies are updated and maintained to continue compliance with existing regulations. The QA committee will review for compliance.
5. Completion date: June 20, 2023

S8018

1. Items impeding the sprinkler in the kitchen were removed. A fire watch plan has been developed.
2. A facility tour was conducted by the Maintenance Director to review all similar areas where storage could impact or obstruct a sprinkler.
3. The sprinkler system education was added to the initial orientation of staff. The Maintenance Director will conduct regular training of staff on the fire suppression system.
4. Staff were educated on proper storage and the 18-inch clearance required to any sprinkler head. Review of sprinklers throughout the facility – and storage areas have been added to the facility Preventive Maintenance plan. The Maintenance Director has indicated the 18-inch mark above any storage areas with a red line as a visual cue for residents and staff.
5. The Executive Director is responsible for ensuring the safety of residents and staff. The Maintenance Director or designee will conduct monthly audits of sprinkler heads and storage

Spoke to Brian Small, Executive Director, by phone on 6/20/2023 @ 8:45 AM and advised him of the Plan of Corrections Acceptance #41673

and report to the Executive Director. Results of these audits will be brought to the QA committee for review.

6. Completion date: June 20, 2023

S8019

1. The fire extinguishers in the kitchen have been inspected.
2. All fire extinguishers in the building were inspected at the time of the survey.
3. A complete inventory of all fire extinguishers and their location in the facility was developed. Each fire extinguisher was assigned a number. The inventory is now used to ensure that all fire extinguishers are inspected monthly. Completion of the fire extinguisher inspections will be documented in the TELS Preventive Maintenance program and on the inventory list. Evidence of completed inspections, using the inventory, will be provided to the Executive Director monthly and kept on file.
4. The Maintenance Director is responsible for this process. The Maintenance Director, or designee, will complete the monthly fire extinguisher inspections. The Executive Director will monitor completion of the inspections. Monthly documentation of fire extinguishers will be brought to the QA committee for review x 3 months. Problems with this process will be brought to the QA committee for resolution.
5. Completion date: June 20, 2023

S8025

1. A night shift fire drill will be conducted no later than June 15, 2023
2. Potentially all residents and staff can be impacted without proper training on fire drills and evacuation procedures.
3. The Maintenance Director has been made aware of the night shift and hours of sleep requirements for future fire drills. The Executive Director and Maintenance Director will work together to ensure that at least two (2) fire drills per year are conducted during prescribed "sleep" times. The Maintenance Director will use the TELS system to monitor and record future drill activities.
4. The Executive Director is responsible for the overall compliance with fire safety measures and the recording of such drills. Audits of drill compliance will be conducted at least semi-annually to ensure compliance. Problems with this process will be brought to the QA committee for resolution.
5. Completion date: June 20, 2023

S8030

1. 1)The oxygen tanks in room 609 have been removed from the floor and placed in containers to prevent them from falling over. The resident who resides in that room and family members have been educated on safe storage of oxygen cylinders. 2) Placards were purchased and placed near each fire extinguisher in the kitchen.
2. 1)Rooms being occupied by other residents were inspected for similar concerns with oxygen cylinders. No other concerns were identified. 2) All other fire extinguishers in the facility were inspected for placards at the time of the survey. No other issues were identified.
3. 1)Staff were educated on the proper storage of oxygen cylinders. Room 609 will be inspected no less than weekly for proper storage of oxygen cylinders by the nursing department. Improper oxygen storage will be corrected immediately, and the Executive Director will be notified by nursing staff. 2)The Maintenance Director and staff were educated on the requirement for the placards near each fire extinguisher. The presence of the placards is now part of the fire extinguisher inspection and is listed on the inventory of fire extinguishers that is the documented evidence of inspections provided to the Executive Director monthly.
4. 1) The Executive Director is responsible for ensuring the safe storage of oxygen. The Executive Director will follow up with the occupant of the room for any safety infractions related to improper oxygen storage. 2)The Maintenance Director is responsible for this process. The Maintenance Director, or designee, will complete the monthly fire extinguisher inspections, including presence of the placard. The Executive Director will monitor the completion of the inspections. Monthly documentation of fire extinguishers will be brought to the QA committee for review x 3 months. Problems with this process will be brought to the QA committee for resolution.
5. Completion date: June 20, 2023

S8999

1. 1)Combustible storage in the boiler room was removed. 2)The self-closure to the door to room 522 was reassembled and now functions appropriately. 3) Supply and drainpipes in the kitchen now have a protective covering.
2. 1) Other storage areas were inspected for similar concerns at the time of the survey. None were found. 2) All other doors with self-closures were inspected to ensure they are properly assembled and working well. 3) Other supply and drainpipes to sinks using hot water were inspected for a similar concern. No concerns were identified.
3. The Maintenance Director was educated on the requirements for proper paint storage, keeping the boiler room free of combustible items, the need for self-closures on doors, and protective coverings on pipes with hot water flowing through them. The boiler room, self-closing doors, and pipes requiring protection have been added to the TELS Preventive Maintenance program for routine inspections. Problems with these areas will be brought to the attention of the Executive Director for discussion on resolution.
4. The Maintenance Director is responsible for this process. Audits of these areas will be documented in TELS. Results of these audits will be brought to the QA committee x 3 months. Problems with this process will be brought to the QA committee for review and resolution.
5. Completion date: June 20, 2023