Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF009	A. BUILDING: ______ B. WING ______	02/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSAROKA SENIOR LIVING	2401 COUGAR AVENUE CODY, WY 82414

(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
S 000	General Comments A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 02/21/2024. The facility was a fully sprinklered, single story building of Type V(111) construction built in 2003. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 51 licensed beds with a census of 47 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 111, 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, 2000 Edition, unless otherwise noted.	S 000		
S8015	NFPA Life Safety - Nfpa Prat from Hazards NFPA 101 Protection from Hazards This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to properly protect hazardous areas in accordance with the 2000 NFPA 101, Life Safety Code. Failure to properly protect	S8015	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THE FACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL.	

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kalli Oberosler	Executive Director	3/14/2024

POC approved via voicemail to Kalli Oberosler on 3/14/24 at 1:15 PM

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S8015	Continued From page 1 hazardous areas could result in the spread of smoke and fire, resulting in injury or death. The deficiency affected three (3) hazardous areas and has the potential to affect all residents, staff, and visitors. The findings were: Observation on 02/21/2024 starting at 11:12 AM revealed that the facility failed to maintain the required smoke partition for all hazardous areas. Observation of the facility maintenance room revealed the space was being utilized for storage of combustible supplies and equipment. It was observed that the door to the facility maintenance room was not equipped with an automatic or self-closing device. Observation of the mechanical mezzanine room revealed the doors to the room were equipped with self-closing devices, but were being continuously propped open with door wedges. Doors protecting hazardous areas shall be self-closing or automatic-closing and shall not be secured in the open position. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2000 NFPA 101 32.3.3.2.2, 8.2.4.3.5	S8015	**CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** On 2/21/24 during survey it was noted that door closed at all times. On 2/21/24 the Maintenance Director ordered a self-closing device and installed the device on 3/7/2024. It was also noted during survey that the mezzanine room located above the kitchen was propped open with door wedges. This was corrected onsite on 2/21/24 once the alleged deficient practice was identified. The doors have self-closing device already installed and doors close automatically. **HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** This alleged deficient practice has the potential to affect all residents, staff and visitors. **MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:** On 3/13/2024 all community staff, including the Maintenance team, have been educated by the Executive Director on ensuring that doors with self-closing devices remain closed at all times and door wedges are not used, and the hazardous areas of the community are properly protected in accordance with the 2000 NFPA 101, Life Safety Code. **HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:** The Maintenance Director/designee will	

			audit the hazardous areas of the community weekly for 4 weeks, then monthly for 2 additional months to ensure all doors have self-closing devices and remain close at all times per 2000 NFPA 101, Life Safety Code. Any findings will be immediately corrected. Performance Improvement (QAPI) Committee will review a summary of findings and provide recommendations for three months. QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director / Designee will be responsible to follow up on any recommendations made by the QAPI Committee. **Date of Compliance: 03/13/2024**	**03/13/2024**
S8027	NFPA Life Safety - Nfpa Emergency Egress & Rel Dr **NFPA 101**	S8027		

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S8027	Continued From page 2 Emergency Egress and Relocation Drills This State Rule and Regulation is not met as evidenced by: Based on document review and staff interview, the facility failed to properly conduct emergency egress and relocation drills in accordance with the 2000 NFPA 101, Life Safety Code, and Wyoming Department of Health (WDH) Ch 12: Program Administration. Failure to properly conduct emergency egress and relocation drills could result in delayed or improper evacuation of the building in the event of a fire, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 02/21/2024 starting at 12:30 PM revealed the facility had not conducted all required emergency egress and relocation drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted one emergency egress and relocation drill in the last twelve (12) months. The facility was unable to provide documentation recording the details of the drill that was conducted. Emergency egress and relocation drills shall be conducted monthly with a minimum of one drill conducted each quarter on each shift, including two at night while residents are sleeping. The drill shall be recorded and include the date, time, type of drill, time required to evacuate all residents and staff, list of anyone who did not evacuate in the required time allowed, and signature and date of the person completing the form. The facility shall meet an evacuation capability rating of either prompt or slow. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref. 2000 NFPA 101 32.7.3; WDH Ch. 12 Section 7, (o)	S8027	PREPARATION AND EXECUTION OF THIS RESPONSE AND PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. FOR THE PURPOSES OF ANY ALLEGATION THAT THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH FEDERAL REQUIREMENTS OF PARTICIPATION, THIS RESPONSE AND PLAN OF CORRECTION CONSTITUTES THEFACILITY'S ALLEGATION OF COMPLIANCE IN ACCORDANCE WITH SECTION 42 C.F.R. 488.18 AND SECTION 7317A OF THE STATE OPERATIONS MANUAL. **CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Additional information on the Fire Drill requirements per the 2000 NFPA 101 Life Safety Code and WDH Ch. 12 Assisted Living was received from the surveyor by Executive Director on 2/21/24. The Executive Director will include this information in the community's Wyoming State Regulations binder. The community has an emergency egress and relocation drill scheduled for 3/20/24 for the evening shift (2p-10p). **HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** This alleged deficient practice has the potential to affect all residents, staff and	

visitors.

MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:

On 3/13/2024 Maintenance Director was educated by the Executive Director on ensuring emergency egress and relocation drills are conducted monthly with a minimum of one drill conducted each quarter on each shift, including two at night while residents are sleeping. The drill will be recorded and include date, time, type of drill, time required to evacuate all residents and staff, list of anyone who did not evacuate in the required time allowed, and signature and date of the person completing the form. The community will determine the evacuation capability rating of whether prompt or slow.

HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED:

The Executive Director /designee will audit the Fire Drill compliance documentation monthly for 3 months until substantial compliance is achieved together with the Maintenance Director to ensure that the emergency egress and relocation drills are conducted in accordance with the 2000 NFPA 101, Life Safety Code and are properly documented. Any findings will be immediately addressed.

Performance Improvement (QAPI) Committee will review a summary of findings and provide recommendations for three months.
QAPI Committee will evaluate and determine the effectiveness of the plan to ensure substantial compliance is achieved and determine if further monitoring and evaluation is required. The Maintenance Director / Designee will be responsible to follow up on any recommendations made by the QAPI Committee.

Date of Compliance: 03/13/2024

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S8027	Continued From page 3	S8027		03/13/2024