Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF008	A. BUILDING: _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA HILLS ASSISTED LIVING COMMUNITY	4606 NORTH COLLEGE DRIVE CHEYENNE, WY 82009

(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 complaint investigation survey was conducted by Healthcare Licensing and Surveys on 04/04/2024 and 04/05/2024. The survey was prompted by complaint intake LIC-24-038. The facility was a two story, fully sprinklered building of Type V (111) construction built in 1997. The building was equipped with a supervised wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 81 licensed beds with a census of 70 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 the 1994 NFPA 101, Life Safety Code, New Residential Board and Care unless otherwise noted.	S 000		
S8002	NFPA Life Safety - Nfpa Minimum Construction Req NFPA 101 Minimum Construction Requirements This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the	S8002		

POC accepted on 5/3/24 via phone call w/ED at 1:20 PM

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S8002	Continued From page 1 facility failed to maintain minimum construction requirements in accordance with 1994 NFPA 101, Life Safety Code. Failure to maintain minimum construction requirements could result in smoke and fire spread resulting in injury or death during an emergency. The deficiency affected numerous areas in the facility. The findings were: Observation on 04/04/2024 at 10:46 AM in one of the dining room alcoves, revealed multiple holes in the ceiling membrane exposing structural members. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.1.3.1	S8002		
S8014	NFPA Life Safety - Nfpa Prot of Vertical Openings NFPA 101 Protection of Vertical Openings This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain vertical openings in accordance with the 1994 NFPA 101, Life Safety Code. Failure to maintain vertical openings as required could result in the spread of fire and smoke throughout the facility, which may result in injury or death during an emergency. The deficiency affected multiple vertical openings and could potentially affect all residents, staff, and visitors. The findings were: Observation on 04/04/2024 at 9:19 AM in the north stairwell revealed an attic access hatch in the open position exposing the attic space to the	S8014		

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S8014	Continued From page 2 potential passage of smoke and fire. Further observation in the south stairwell revealed the same deficiency. All interior stairs serving as an exit or exit component shall be enclosed. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.3.1, Ch. 6 Sec. 2.4.4, Ch. 5 Sec. 1.3.1(e) and 2.2.6.1	S8014		
S8015	NFPA Life Safety - Nfpa Prot 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 maintain hazardous areas in accordance with the 1994 NFPA 101, Life Safety Code. Failure to hazardous areas as required could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected two (2) hazardous areas and could potentially affect all residents, staff, and visitors. The findings were: Observation on 04/4/24 at 9:35 AM at the resident laundry room adjacent to the maintenance office revealed that the self-closing door failed to operate as designed. When drop tested with no initial motion, the door failed to close and latch. Further observation revealed the maintenance office door was held open by a door chalk. Any hazardous area shall be protected by an automatic sprinkler system, and separation that will resist the passage of smoke between the hazardous area and the sleeping area or primary	S8015		

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S8015	Continued From page 3 escape route. Any doors in such separation shall be self-closing or automatic-closing. Interview with the maintenance supervisor at the time of observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 1994 NFPA 101, Ch.22 Sec. 2.3.2	S8015		
S8027	NFPA Life Safety - Nfpa Emergency Egress & Rel Dr NFPA 101 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 conduct fire exit drills in accordance with NFPA 101, Life Safety Code and Wyoming Department of Health (WDH) Chapter 12 Rules, Program Administration for Assisted Living Facilities. Failure to conduct fire exit drills as required could result in delayed egress during an emergency leading to injury or death. The deficiency could potentially affect all residents, staff, and visitors. The findings were: 1. Document review on 04/04/2024 starting at 1:00 PM and 04/05/2024 starting at 8:00 AM revealed the facility had only been exercising one wing of the facility per drill, instructing other residents to remain in their rooms and close the doors. This is according to the facilities written fire drill instructions to staff. NFPA 101 states that drills shall involve the actual evacuation of all	S8027		

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S8027	Continued From page 4 residents to an assembly point. Residents that cannot meaningfully assist in their own evacuation, or who have special health problems, shall not be required to actively participate in the drill. Section 18.7 shall apply in such instances for those residents. Residents that require assistance shall be indicated in the facility's Evacuation and Relocation plan. Document review did not demonstrate that the facility's plan contained such language. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.5, Ch. 31 Sec. 1.5 2. Document review on 04/04/2024 starting at 1:00 PM and 04/05/2024 starting at 8:00 AM revealed the facility did not demonstrate they provided a contract for outside hospice services identifying the clear delineation of services pertaining to Life Safety Code responsibilities. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: WDH Chapter 12, Sec. 9 (a)(ii)	S8027		
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 handle in-use oxygen containers	S8030		

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S8030	Continued From page 5 within resident rooms in accordance with NFPA 99, Standard for Health Care Facilities. The failure to appropriately handle in-use oxygen containers as required could result in injury or death. The deficiency affected multiple the resident rooms in the facility and could potentially affect the residents, staff, and visitors of those rooms. The findings were: Observation on 04/04/2024 at 9:23 AM in room 130 revealed oxygen cylinders that were not secured from falling. This deficiency was discovered in additional resident rooms throughout the facility. Oxygen storage containers must be secured against damage at all times. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 1993 NFPA 99, Section 8-3.1.11 2. Based on observation and staff interview, the facility failed to maintain a clear egress in resident rooms in accordance with the NFPA 101, Life Safety Code. Failure to maintain a clear means of egress as required could delay egress resulting in injury or death in the event of an emergency. The deficiency affected one (1) resident room in the facility and could potentially affect the residents, staff, and visitors of that room. The findings were: Observation on 04/04/2024 at 11:47 AM in room 231 revealed an excessive amount of items in the room impeding ingress and egress to and from the room. Further observation revealed a curtain hanging in the room further obstructing view of the egress door. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Hangings or draperies shall	S8030		

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S8030	Continued From page 6 not be placed over exit doors or located so that they conceal or abscure any exit. Interview with the administrator at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101, Ch. 22 Sec. 3.2, Ch. 5 5.2.2 and 5.4.2	S8030		

Edgewood

Sierra Hills Assisted Living Community Survey Date: 04/05/2024 Identification Number: ALF008

S8002

Maintenance Director called a local drywall company on April 26th 2024 to set up service to repair multiple openings in the dining room alcove caused by pipe bursts. The local drywall company will patch the holes May 7-10.

S8014

Hatch closed on April 5th 2024. Maintenance Director called Life Safety Office on April 10th 2024 to verify that taping and sealing is appropriate to do. Maintenance Director will review the expectations with staff at the next mandatory staff meeting to be held on May 16th 2024.

S8015

Maintenace Director removed door handle on April 29th 2024 of south laundry room door adjacent to maintenance office and lubed the striker. Upon multiple tests, the door closes and latches on its own. Maintenance Office door will be closed during all times that it is not occupied.

S8027

1. Please see attachment 1 for building fire drill procedure. Resident evacuation status is included and is reviewed by Maintenance Director and Clinical Services Director monthly.
Sierra Hills Assisted Living will conduct a full building evacuation on or before May 31st 2024 and at each subsequent drill.

2. Evacuation plans for residents receiving hospice services from any entity will have a plan in their individual care plan and a copy to be kept in the resident folder that will be located on or around the refrigerator in resident room. Resident evacuation plans will be in folder no later than May 31st 2024 and upon admission onto hospice services going forward.

S8030

1. On April 5th 2024, Executive Director contacted oxygen companies that service residents of Sierra Hills to ensure that all oxygen tanks have a rack or box depending on the size of the bottle in each resident apartment. On April 26th 2024, Executive Director and Maintenance Director performed and audit on all residents room on oxygen placement and storage. One room was found to be uncompliant. This was taken care of after the audit was completed by placing a rack in the apartment and putting the tanks in the rack. Maintenance Director will go over the safety aspects of proper storage of oxygen with residents at the next scheduled Resident Council to be held on May 2nd 2024. He will also communicate that tanks are not to be used as door stops. At the next mandatory all staff meeting to be held on May 16th 2024, staff will be told to be aware of oxygen storage and to notify management if they find tanks not in compliance.

Address
Address
T Phone
F Fax
email

Edgewood

Sierra Hills Assisted Living Community Survey Date: 04/05/2024 Identification Number ALF008

S8030

2. Executive Director reached out to family prior to survey to help resident with cleaning and decluttering apartment number 231. Family has set up a private housekeeper who began work on April 23rd 2024 and will hereafter return each Tuesday to provide weekly cleaning and clutter removal. The curtain that obstructed the view of the egress door was removed by Sierra Hills staff on April 26th 2024.

S5003

1. Please see attachment 2 for the soiled linen policy of EDGEWOOD Senior Living Communities. Education will be provided to staff at the next scheduled mandatory all staff meeting to be held on May 16th 2024 going over proper handling of soiled articles through the building.

2. During next mandatory all staff meeting to be held on May 16th 2024, education will be provided to staff on how to clean the laundry machines per OSHA recommendations. This education consists of: after soiled linen is cleaned in washing machine, the multi-purpose peroxide cleanser provided by Sierra Hills is to be sprayed in the machine wetting all surfaces to sanitize for the next user.

3. EDGEWOOD is currently reviewing the soiled linen policy and will update the company Clinical Services Manual at that time. See attachment 2 for the current policy in place.

S5048

1. a. Please see attachment 3 for the documentation of WHO, WHAT, WHEN, WHERE and HOW outside services will be provided by Caring Edge Hospice.

b. EDGEWOOD is in the process of creating a training program for CNA 2 and CMA. CNA 2 training will begin May 14th-16th 2024. Once there are CNA 2s on staff, a CMA class will be offered. A Certified Medical Assistant will be able to administer medications overnight. Until this plan is completed, Sierra Hills and hospice entities practicing at Sierra Hills will have a nurse on call on rotation to ensure proper medications are dispensed throughout the nighttime hours.

c. Caring Edge Hospice has an on-call service for Sierra Hills to use when a staff member is not in the building. The service then calls the nurse on call to come to the community. After the incident listed in this notation, the nurse on call was let go from Caring Edge Hospice the next day.

2. Please see the above information in point number 1. on plan for medication administration for residents on hospice.

Address
Address
T Phone
F Fax
edgewoodseniorliving.com