NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
SUGARLAND RIDGE, ALF	1551 SUGARLAND DRIVE, SHERIDAN WY	1/29/09

SUMMARY OF DEFICIENCY	FACILITY PLAN OF CORRECTION	FACILITY COMPLETION DATE
An annual Health and Life Safety Code survey was conducted at your facility by the Office of Healthcare Licensing and Surveys (OHLS) on 1/28-29/09. 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). **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. This REGULATION was not met as evidence by 1. Based on observation and staff interview, the facility failed to maintain the fully sheathed surfaces of the building. The findings were: Observation revealed the kitchen wall had a 12 x 12 inch hole cut out of it at the ceiling juncture exposing a water pipe. In addition, in the ceiling at approximately 3 ft. from the exposed pipe, there was a 4 inch circular hole. Interview with the maintenance manager revealed there had been a plumbing leak and the hole in the wall had to be out in order to access the pipe. He also stated the hole in the ceiling was where a sprinkler head had to be removed for repairs as a result of the leak.	1. Kitchen wall had a 12x12 inch hold cut out of it at the ceiling junction exposing a water pipe. In addition, in the ceiling approximately 3ft from the exposed pipe, there was a 4 inch circular hole. Hole in kitchen wall was fixed on 2/29/09 by Environmental Services Director. Hole approximately 3 ft from the exposed pipe was also fixed on 2/29/09 by Environmental Services Director.	

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Wyoming Dept of Health
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Office of Healthcare Licensing & Surveys

Provider Representative's Signature/Title — Date

POC approved 4/2/09 a/w Contact & Adm.

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Reference NFPA 101 Life Safety Code, 1988 Edition: "22-3.1.3.1 Construction requirements for large facilities shall be as required by this section. Where noted as "fully sheathed", the interior shall be covered with a lath and plaster or material providing a 15-minute thermal barrier."		
2. Based upon observation and staff interview, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13. The findings were: Observation showed the closets in resident rooms #307, #312 and #315 had storage located within 18 inches of the closet sprinkler head. Interview with the facility administrator verified storage was located within 18 inches of the sprinkler heads. *Reference NFPA 101 Life Safety Code, 1994 Edition NFPA 101, Chapter 32 Referenced Publications: NFPA 13, Installation of Sprinkler Systems, 1999 edition.* *"5-6.5.3* Obstructions that prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section."*	2. Closets in resident rooms #307, #312 and #315 had storage located within 18 inches of closet sprinkler head. ES Director on 1/30/09 lowered residents belongings to within 18 inches of closet sprinkler head. Will be monitored by Administrator and ES Director.	
3. Based on record review and staff interview, the facility failed to maintain the installed fire alarm system in accordance with the provisions of NFPA 72. The findings were: Review of facility's records on 1/28/09 at 3:48 PM revealed the facility was equipped with an annunciator panel, two smoke duct detectors, nineteen heat detectors, twenty-four pull stations, one hundred fifty nine smoke detectors, two waterflow devices, seventeen photo smoke detectors and one air pressure switch. However, observation on 1/28/09 at 4:04 PM revealed two smoke detectors (room #2D and in the third floor stairwell) were missing from the ceiling. Interview with the administrator at the time of the observation revealed the floor above room	3. Two smoke detectors (room #2D and in the third floor stairwell) were missing from the ceiling. The two smoke detectors were replaced by Comtronic on 2/24/09.	

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2D had a plumbing leak and had damaged the smoke detector. *Reference NFPA 101 Life Safety Code, 1994 Edition "7-6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with...NFPA 72, National Fire Alarm Code."* 4. Based on observation and staff interview the facility failed to ensure two smoke barrier doors would resist the passage of smoke. The findings were: Observation on 1/28/09 at 4:13 PM revealed the self-closing corridor door tht allowed entry into the elevator holding area on the third floor did not fully latch when allowed to close. In addition, the self-closing corridor door that allowed entry into the third floor laundry room did not fully latch when closed. Interview with the maintenance staff verified the above two doors would not fully close. *Reference NFPA 101 Life Safety Code, 1994 Edition "22-3.3.6.5 Walls and doors required by 21-3.3.6.1 and 21-3.3.6.2 shall be constructed to resist the passage of smoke...."* *"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."* *"5-2.1.8 Self-Closing Devices. A door designed to normally be kept closed in a means of egress, such as a door to a stair enclosure or horizontal exit, shall be a self-closing door and shall not be secured in the open position at any time."* 5. Based on observation and staff interview the facility failed to ensure three emergency exit lights were fully illuminated. The findings	4. Self-closing corridor door that Allowed entry into the elevator did not fully latch. In addition, the self-closing corridor door that allowed entry into third floor laundry room did not fully latch. Both these doors were fixed on 1/30/09 by ES Director.	

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were: Observation showed light bulbs were burned out in three emergency exit signs at the following locations: a) the south entrance, b) the northeast entrance into the dining room and c) the hallway entrance into the dining room. Interview with the facility's administrator and maintenance manager confirmed the bulbs were burned out. *Reference NFPA 101 Life Safety Code, 1994 Edition "5-8.1.4 Any required illumination shall be arranged so that the failure of any single unit, such as the burning out of an electric bulb, will not leave any area in darkness."* **Chapter 12. Section 6. Personnel and Staffing Requirements.** (c) Background checks All staff of the ALF shall successfully complete a State of Wyoming DCI background check and a DFS Central Registry Screening before direct resident contact. This REGULATION was not met as evidenced by: Based on personnel record review and staff interview the facility failed to conduct a DCI or a DFS background check on one (#3) of five employees prior to employment. The findings were: Review of employee records for employee #3 revealed the employee was hired on 10/1/08 to assist with medications. Further review of the employee's file revealed no documentation a DCI or DFS background check was conducted. Interview with the facility administrator on 1/29/09 verified the employee did not have a background check conducted prior to employement. Chapter 12. Section 6. Personnel and Staffing	5. Light bulbs burned out in three emergency exit signs at the following locations: a) south entrance, b) northeast entrance into dining room, c) hallway entrance into the dining room. All three of these exit signs were fixed on 1/30/09 by ES Director. Exit signs will be monitored by ES Director. (c) Review of employee records for employee #3 revealed the employee was hired on 10/1/08 to assist with medications. Further review of the employee's file revealed no documentation a DCI or DFS background check was conducted. All employees will have DCI or DFS background Checks prior to employment. This will be monitored by Administrator.	7 mo hire, #3

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Requirements. (d) Infection Control (ii) Tuberculin Testing (TB) (A) Tuberculin testing must be accomplished for each employee prior to employment and annually thereafter. This REGULATION was not met as evidenced by: Based on personnel record review and staff interview the facility failed to ensure TB testing on one of five employees prior to employment. The findings were: Review of employee records for the kitchen manager revealed the manager was hired on 2/13/08. Further review of the file revealed the employee did not have a TB skin test until 3/25/08, over a month after starting employment. Interview with the facility administrator on 1/29/09 verified the employee did not have a TB skin test prior to employment. **Chapter 12. Section 7. Assisted Living Facility (ALF) Core Services.** (s) Evacuation Capability, Emergency Procedures, and Fire Safety. (iii) Fire Safety. (A) Portable fire extinguishers shall be installed, inspected, and maintained according with NFPA 10, Standard for Portable Fire Extinguishers. This REGULATION was NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect 1 of 18 portable fire extinguishers monthly in accordance with NFPA 101, Section 22.3.3.5.3, 7-7.4.1, and NFPA 10, Section 4-3.1. The findings were:	(d) Review of employee records For kitchen manager revealed The manager was hired on 2/13/08. Further review of the file revealed the employee did not have a TB skin test until 3/25/08, over a month after starting employment. TB tests will be performed prior to employment on every employee. Will be monitored by Administrator and Resident Care Coordinator. (s) Observation on 1/28/09 at 2:15 PM revealed the kitchen K-type extinguisher was not inspected on a monthly basis. Extinguisher was inspected On 1/30/09 by ES Director. This will be monitored by ES Director.	

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Observation on 1/28/09 at 2:15 PM revealed the kitchen K-type extinguisher was not inspected on a monthly basis, such that a three month time period elapsed from 10/23/08 to 1/28/09. In addition, the K-type extinguisher had a blue residue accumulation on the neck of the extinguisher. Interview with the facility's maintenance manager confirmed he had not inspected the extinguisher on a monthly basis and stated he would get the extinguisher inspected in order to determine the source of the blue residue. *"Reference NFPA 101 Life Safety Code, 1994 Edition":* *"22-3.3.5.3 Portable Fire Extinguishers. Portable fire extinguishers in accordance with 7-7.4.1 shall be provided near hazardous areas."* *"7-7.4.1 ...Portable fire extinguishers shall be installed in accordance with NFPA 10, Standard for the Installation of Portable Fire Extinguishers."* *"NFPA 10 Standard for the Installation of Portable Fire Extinguishers"* *"4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals...."* **Chapter 12. Section 7. Assisted Living Facilities (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 REGULATION was not met as evidenced by: Based on medical record review and staff. interview the facility failed to complete an ALF 102 form prior to admission for 3 (#1, #2, #3) of 3 sample residents. The findings were: 1) Record review revealed resident #1 was admitted to the facility on 12/18/08. However,	(b) Based on medical record review and staff interview the facility failed to complete an ALF 102 form prior to admission for 3 (#1, #2, #3) of 3 sample residents. ALF 102 will be completed prior to move in and annually on each resident. Will be monitored by Administrator and RCC.	

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the admission ALF 102 was not signed by the nurse until 12/29/08. 2) Record review revealed resident #2 was admitted to the facility on 6/27/08. However, the admission ALF 102 was not signed by the nurse until 7/10/08. 3) Record review revealed resident #3 was admitted to the facility on 11/13/08. However, the admission ALF 102 was not signed by the nurse until 11/25/08. Interview with the facility administrator on 1/29/09 verified the resident's ALF 102's were signed after admission. **Chapter 12. Section 7. Assisted Living Facilities (ALF) Core Services.** (m) Facility Policies and Procedures (i) Management shall develop policies and procedures that are available to residents and staff, including but not limited to: (C Admission, transfer, discharge of residents. This REGULATION was not met as evidenced by: Based on review of the facility policies and procedures and staff interview the facility failed to update their transfer and discharge policy. The findings were: Review of the facility's transfer policy stated, "...residents shall be given 14 days notice prior to discharge." Chapter 12 of Program Administration of Assisted Living Facilies states in Section 7, (k) Transfer and Discharge, (i) Residents shall receive a thirty (30) day written notice prior to any facility initiated transfer or discharge. Interview with the facility administrator on 1/29/09 verified the facility's policies and procedure relating to resident transfer and discharge was not up to date.	(m) Transfer policy stated, "....residents shall be given 14 days notice prior to discharge." Policy will be revised by 3/31/09 to be in compliance with Chapter 12 regulations.	