NAME OF FACILITY	FACILITY ADDRESS	DATE OF SURVEY
SUGARLAND RIDGE, ALF	1551 SUGARLAND DRIVE, SHERIDAN WY	6/5/07 TO 6/7/07
SUMMARY OF DEFICIENCY	**FACILITY PLAN OF CORRECTION**	**FACILITY COMPLETION DATE**
A Health and Life Safety Code survey was conducted at your facility on June 5 through 7, 2007 by the Office of HealthCare Licensing and Survey (OHLS) **Chapter 4. Rules and Regulations for Licensure of Assisted Living Facilities.** 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: A. Based on observation and staff interview on 6/6/07, the facility failed to maintain the installed cooking equipment and protection systems in accordance with the provisions of NFPA 96. The findings were: On 6/6/07 at 2:15 PM, the facility was unable to provide documentation that the kitchen exhaust hood had been cleaned since 10/20/05. Staff interview confirmed no other	Bob's Super Clean (a trained and qualified cleaning vendor) is scheduled to clean our kitchen hood ventilation system on July the 9th. System will be placed on a service schedule so that the system is cleaned every 6 months. These visits will be documented.	07-10-07 Monitored by Dietary Supervisor and Maintenance Supervisor

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JUL 10 2007
Wyoming Dept of Health
Licensing and Surveys

Wyoming Dept of Health
Licensing and Surveys

Doug Williams
Provider Representative's Signature/Title

7/8/07
Date

Approved 8/23/07 c New Administrator (Kristy Massengill)

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documentation could be found. A. Reference NFPA 101-Life Safety Code, 1994 Edition NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2001 Edition 11.2.1 An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.		
B. Based upon observations on 6/6/07 at 9:26 AM, the facility failed to maintain the installed sprinkler system in accordance with NFPA 25. The findings were: The sprinkler head in the closet in resident room 114 was covered with tape. (Reference NFPA 101, Chapter 32 Referenced Publications NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.)	Inspect all sprinkler heads within community by 07.31.07, and then thereafter annually.	07-31-07 monitored by Maintenance and Safety Committee

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C. Based on observation and staff interview on 6/6/07 between 12:30 PM and 4 PM, the facility failed to maintain the fully sheathed surfaces of the building. The findings were: 1. The closets in resident rooms #304 & #317 each had a gap between the sprinkler escutcheon and the wall resulting in a 1-inch penetration. 2. The facility gym room had an open air vent in the ceiling that was approximately one foot square where the ceiling fan had been removed. 3. A 3-inch square hole was cut in the wall in the dining room behind the television set to allow for cable penetration. 4. Facility staff verified the above. C. 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." D. Based on observation and staff interview the facility failed to thoroughly document the monthly generator test in accordance with the provisions of NFPA 110. The findings were: On 6/6/07 at 10:48 AM, complete documentation was not provided to	1) Apartments #304 and #317 are scheduled for repair on July 2nd, 2007. The maintenance department will inspect all rooms and correct findings. 2) Exhaust Air Vents: a) An extra air vent cover was ordered which will be used to cover the vent hole while a motor is being repaired on replaced. b) We have ordered spare motors so that we can replace any needing repair, and thus will not leave a vent open except when being worked, on by the maintenance personnel in the room or apartment. 3) Hole in dining room (behind the television was properly repaired with a material which was identified to meet the 15 minute thermal barrier. New covers were placed upon the television cable box. 4) Sprinklers shall be checked at least annually, and results will be documented. D. Monthly Generator Documentation of Services. • Maintenance Staff has placed the	07-10-07 monitored by Maintenance Supervisor 07-20-07 monitored by the Maintenance Supervisor 06-29-07 monitored by the Maintenance Supervisor 8-31-07 monitored by the Maintenance Supervisor 6-29-07 monitored by the Maintenance

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indicate monthly generator tests were completed. Staff interview confirmed the only generator documentation of testing was transfer time. Percent loading, generator temperature, and load duration were not documented. D. Reference NFPA 101-Life Safety Code, 1994 Edition 22-3.2.9 Emergency Lighting. Emergency lighting in accordance with Section 5-9 shall be provided in all buildings with more than 25 rooms. 5-9.2.3 Emergency generators used to provide power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.... NFPA 110, Standard for Emergency and Standby Power Systems, 2002 edition 8.4.2 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating (2) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer E. Based on observation and staff interview on 6/6/07 between 9 AM and 11 AM, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 & 25. The findings were:	generator upon its monthly preventive inspection routine. o Check the oil: ▪ Assure oil changed per manufacture's ▪ recommendations. ▪ Assure oil kept at appropriate level. o Check the cooling system: ▪ Assure antifreeze mixture is appropriate for our climate(s). ▪ Check the coolant temperature while under load and assure the heat level is appropriate. o Check Battery to assure it is holding charge per manufacture's recommendation. ▪ Replace battery as needed. • Documentation will be kept on the above items. 1) Generator Testing. a) Testing will be performed under operating temperatures at 30% or more of the EPS nameplate KW rating. b) Exhaust temperatures outside the manufacture's recommendations will be recorded and appropriate qualified service vendor will be contacted. c) Exhaust temperatures will be documented and maintained.	Supervisor 07-20-07 monitored by Maintenance Supervisor

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1. Each closet in resident rooms #321, #322, #315, and #312 had items stored within 18 inches of the sprinkler head. The facility administrator verified the distance. 2. The facility failed to provide documentation that the dry sprinkler system had been trip tested in the past 12 months. The most recent documentation of trip testing was dated 7/29/05. Maintenance staff verified this was the most recent documentation available. E. Reference NFPA 101 Life Safety Code, 1994 Edition ANFPA 101, Chapter 32 Referenced Publications: ANFPA 13, Installation of Sprinkler Systems, 1999 edition. "2 2.6.2* Escutcheon plates used with a recessed or flush type sprinkler shall be part of a listed sprinkler assembly." "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." "NFPA 25, Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 edition." "9 2.7 Waterflow alarm. All waterflow alarms shall be tested quarterly in accordance with	Fire Prevention Sprinkler System: 1) 18 inches of clearance: a) Residents of mentioned apartments were educated to the requirement that no items can be stored within 18 inches of the ceiling. b) The 18-inch requirement will be inspected and reported on a semi-annual basis. c) New Admissions will have this requirement reviewed prior or during move in. d) Resident handbook to reflect wording re: the 18-inch restriction. 2) Dry sprinkler system – trip test – 12 months: a) Dry sprinkler system – trip test will be documented showing the test was performed within the last 12 months.	06-29-07 Monitored by Housekeeping Supervisor and Maintenance Supervisor 07-20-07 monitored by Maintenance Supervisor

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manufacture's instructions." F. Based on record review and staff interview, the facility failed to maintain, test, and document the installed fire alarm system in accordance with the provisions of NFPA 72. The findings were: Observation and record review on 2/24/04 between 3 PM and 4 PM revealed the facility was equipped with an annunciator panel, 2 smoke duct detectors, 18 heat detectors, 24 pull stations, 160 smoke detectors, 2 waterflow devices, 17 photo smoke detectors, 1 air pressure switch, and 2 water flow devices. Record review revealed the system was last inspected in April 2006. Further record review revealed the air pressure switch was not tested. In addition, 3 of the 160 smoke detectors failed testing. Facility staff confirmed the signal device was not tested. Staff did not know if the smoke detectors had been replaced or fixed. F. Reference NFPA 101 Life Safety Code, 1994 Edition NFPA 101, Chapter 32 Referenced Publications: NFPA 72, National Fire Alarm Code, 1999 edition. Table 7 3.2 15. Initiating Devices j. Supervisory Signal Devices, tested quarterly	Emergency Detection Equipment, such as smoke duct detectors, pull stations, smoke detectors, water flow devices, photo smoke detectors, air pressure switches and water flow devices shall be inspected annually, and results will be documented. To be completed by 08.31.07	08-31-07 monitored by Maintenance Supervisor and Safety Committee

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G. Based on observations and staff interview the facility failed to provide an electrical system installed in accordance with NFPA 70. The findings were: On 6/6/07 at 11:45 AM, observation revealed an electric wall heater was removed from the wall heater box in the public restroom on the third floor. Exposed wires were observed in the heater box. Maintenance staff verified the heater assembly was removed from the heater box for repair. G. Reference NFPA 101 Life Safety Code, 1988 Edition: ANFPA 101, Chapter 32 Referenced Publications: ANFPA 70, National Electrical Code, 1999 edition: A370 28. Pull and Junction Boxes. (3) (c) cover. All pull boxes, junction boxes and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use....	Electric Wall Heater (Exposed Wires) 1) A compatible cover plate was placed on the 3rd floor public bathroom heater box. 2) Extra motors (2) were ordered so maintenance staff can replace motors needing repair immediately, and thus prevent the potential exposure of electrical wires. 3) An inspection will be made by maintenance staff and any covers broken or missing will be fixed immediately. To be completed by 08.31.07 4) Maintenance will maintain documentation concerning broken or missing covers.	06-29-07 monitored by Maintenance Supervisor
H. Based on observation and staff interview on 6/6/07 between 10:30 AM and 3 PM, and again on 6/7/07 at 9:15 AM, the facility failed to assure 3 smoke barrier doors would resist the passage of smoke. The findings were: 1. The north exit self-closing corridor door, which allowed access to the third floor stairwell, and the north exit self-closing corridor door, which allowed access to the second floor	1) Self Closing Smoke Barrier Door 3rd floor north exit: a) North exit self-closing corridor door was planed on the bottom, thus	06-29-07 monitored by safety committee

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stairwell would not swing freely when opened. The carpet underneath the doors was noted to jam underneath the doors, holding them in an open position and preventing them from closing. 2. The self-closing corridor door, which allowed entry into the elevator holding area on the third floor, did not fully latch when allowed to close. Maintenance staff verified the above doors would not fully close. 3. A fire drill was conducted on 6/7/07. Observation revealed the magnetic hold-open devices did not release one of the two corridor doors to the third floor conference room or the elevator access area door to the second floor elevator holding area. In addition, the resident laundry room door on the first floor was impeded by a rubber wedge preventing the doors from fully closing. H. 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,	allowing it to completely close, and yet resist the passage of smoke. 2) Self Closing Smoke Barrier Door 3rd floor elevator holding area: a) 3rd floor elevator holding area door was planed at the bottom, thus allowing it to completely close, and yet resist the passage of smoke. 3) Self Closing Smoke Barrier Door 3rd Conference Room & Laundry Room: a) We have tested this door several times and it has closed during our test. We have requested our vendor to test it while he is here (check for low voltage, etc.) At this time we are unable to have it performed the way it did during the inspection. Will continue to monitor it. b) Laundry Room door propped open. i) Signs have been placed on laundry room doors, requiring that these doors not be propped open by another or for any reason. Stops/wedges to be removed. ii) Staff has been instructed to confiscate any wedge found propping doors open. An in-service including the staff's name and date of education will be placed in the employee's file.	and Maintenance Supervisor 06-29-07 monitored by safety committee and Maintenance Supervisor 07-20-07 monitored by Maintenance Supervisor b) - 06-29-07 monitored by safety committee and Maintenance Supervisor

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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." **Chapter 12. Program Administration for Assisted living Facilities** Section 6. Assisted Living Facility (ALF) Core Services. (s) Evacuation Capability, Emergency Procedures, and Fire Safety. (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. This regulation was NOT MET as evidenced by: Based upon record review on 6/6/07, at 10:48 AM, the facility failed to conduct one fire drill on each shift per quarter. The findings were:	Fire Drills: 1) Our community recognized the fact that we missed one fire drill. a) Our safety committee has met to assure that future fire drills are as follows.	06-29-07 monitored by Safety Committee and Executive Director

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During the previous 12 months: a. Six fire drills were held during the day shift. b. Three fire drills were held during the evening shift. c. Two fire drills were held during the night shift. d. In addition, documentation was unavailable for any fire drill held during February 2007. Maintenance staff verified the above and confirmed there were no other records to review. Section 6. 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 27 of 27 portable fire extinguishers on a monthly basis 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: Observation on 06/5/07 between 11:15 AM and 3:06 PM revealed the monthly inspections of all portable fire extinguishers in the facility were not done for the past 12 months. The facility manager stated he was unaware of this requirement.	i) Fire drill documentation will be kept and available for review for a minimum of 2 years. ii) 12 fire drills will be performed per year. (1) Four drills on the Day Shift (2) Four drills on the Evening Shift (3) Four drills on the Night Shift. b) Our Safety Committee will bring the previous 12 months of fire drills to our quarterly QA committee meeting for review. 2) Additional fire drill to be completed for the night shift by 07.31.07. Portable Fire Extinguishers: 1) Maintenance staff will inspect portable fire extinguishers at least every 30 days or more often as necessary to meet the intent of the regulation. 2) Documentation of all 27 portable fire extinguishers will be maintained. a) Assuring that the appropriate inspection was performed. b) Assure that all portable fire extinguishers are recharged or replaced per regulations.	06-29-07 monitored by Maintenance Supervisor and Safety Committee

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"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...." Section 6. Assisted Living Facilities (ALF) Core Services. (b) Resident Assessment and Services. (i) The completion of the ALF 102 (II) The ALF 102 form must be completed and signed by an RN. (ii) Admission orders. A resident shall be admitted only if accompanied by a history and physical completed by a physician or physician extender within ninety (90) days prior to admission. The facility shall confirm the resident's medication regimen and special treatment orders at the time of admission. This REGULATION was not met as evidenced by: Based on medical record review and	Resident Assessment and Services 1) ALF 102 form and history physical a) ALF 102 will be completed prior to a	06-29-07 monitored by Business

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staff interview the facility failed to complete an ALF 102 form and obtain a history & physical for one of 6 sample residents (#2) upon admission. The findings were: Review of the medical record for resident #2 revealed the resident was admitted to the facility on 6/2/07. There was no evidence of a completed ALF 102. Nor was a history and physical included in the medical record. Interview with the facility administrator on 6/7/07 at 10:20 AM verified the resident's medical record was incomplete. Section 6. Assisted Living Facilities (ALF) Core Services. (I) Transfer and Discharge (iii) Residents transferred to another health care facility shall be given written transfer/ discharge notice which includes: (A) The name of the resident. (B) The reason for the transfer/ discharge. (C) The date of the transfer/ discharge. (D) The location to which the resident is transfer/ discharge.	resident being admitted b) A history and physical will be obtained prior to a resident being admitted. 2) Nursing will review all admissions of residents and any deficient findings of this regulation will be corrected as necessary.	Office Manager and Executive Director
This REGULATION was not met as evidenced by: Based on medical record review and staff interview the facility failed to have a written discharge summary for two of three sample residents (#8, #9) transferred from the facility. The	Transfer and Discharge 1) Our Nursing Staff has reviewed this deficiency and will perform the following for all transferred or discharged. a) Provide a written transfer/discharge notice with includes	06-29-07 monitored by Business Office Manager and Executive Director

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findings were: Review of the medical record on 6/6/07 revealed the both residents had been discharged from the facility during the previous six months. There was no evidence regarding the reason for the discharge, when the residents were discharged, or to where the residents were being discharged in their medical records. Interview with the facility office manager on 6/6/07 at 11:48 AM revealed both residents were discharged to another health care facility. Interview with the facility administrator on 6/7/07 at 10:20 AM verified each resident's medical record was incomplete and should have contained a discharge summary. Section 6. Assisted Living Facilities (ALF) Core Services: (r) Furnishings, Building Physical Plant. (ii) Sleeping rooms shall be homelike, well lighted and ventilated This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the ceiling ventilation fan in the bathroom located in 1 of 52 resident apartments (apt #105).The findings were: Observation on 6/6/07 at 3:48 PM revealed the ventilation fan in the bathroom of apartment #105 was nonfunctional. Interview with the	i) The name of the resident. ii) The reason for the transfer / discharge. iii) The date of the transfer / discharge. iv) The location to which the resident is transfer / discharge. 2) Nursing staff will review all discharges and transfers of residents in the previous 90 days and document all deficient findings of this regulation. Furnishings, Building Physical Plant. (ii) Sleeping rooms shall be homelike, Well lighted and ventilated. 1) Facility has installed a new fan in apartment 105. 2) Facility has purchased extra fans so that when a fan needs repaired/replaced, we can take a fan from our inventory and do the repairs immediately.	06-29-07 monitored by Maintenance Supervisor

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facility administrator at that time verified the status of the fan. Section 6. Assisted Living Facilities (ALF) Core Services: (p) Personnel Policies and Records (ii) A record for each employee shall be maintained and contain at a minimum (G) Documentation of tuberculin testing (K) Licensure, Certification This STANDARD is not met as evidenced by: Based on personnel record review and staff interview the facility failed to ensure tuberculin (TB) testing certification documentation for 1 of 4 sample employees (CNA #1). The findings were: Review of the personnel records on 6/6/07 revealed Certified Nursing Assistant (CNA #1) was hired on 2/23/07. The file failed lacked documentation that a TB test was performed during the previous year. In addition, the file also failed to contain documentation the employee was a CNA or if her license was current. Interview with the facility office manager on 6/6/07 at 11:45 AM verified that the employee was a CNA and her nurse aide certification and her TB testing results were missing from her file. Interview with the facility administrator on 6/7/07 at	Personnel Policies and Records 1) We have reviewed and up-dated our check of list to assure new employees have provided all the necessary information and past the required TB test prior to working in our community. 2) A record for each employee will contain at a minimum the following: a) Documentation of tuberculin testing b) Licensure, Certification 3) Our office manager will review all employees, assuring all employees have the required information in their files. All deficient files will be corrected by 10.31.07. All new hire will be reviewed before the employee begins.	06-29-07 monitored by Business Office Manager and Executive Director

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10:26 AM confirmed the employee's personnel and medical files were incomplete.		