

Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF014 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED R 12/13/2023 |
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| NAME OF PROVIDER OR SUPPLIER SPRING WIND ASSISTED LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 1072 NORTH 22ND STREET LARAMIE, WY 82072 |
|---|--|

| (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 |
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{S 000}

General Comments

A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 12/13/2023 for all previous deficiencies identified on 10/11/2023. Additional instances of non-compliance were identified during the revisit survey, and are included below.

{S 000}

{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 protect cooking equipment in accordance with the 1994 NFPA 101, Life Safety Code, and the 2008 NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Failure to properly protect cooking equipment could lead to equipment damage or improper protection by fire suppression systems, resulting in injury or death during an emergency. The deficiency affected the kitchen and all staff within. The findings were:


Observation on 10/11/2023 at 10:14 AM revealed a wheeled gas-fired cooktop beneath a grease hood and fire suppression system with no means to ensure the cooktop is returned to the approved location after being moved for service or cleaning.

-CORRECTED-Observation during the revisit survey on 12/13/2023 at 10:50 AM revealed the floor had been marked to create a repeatable means to return the cooktop.

2. Based on observation and staff interview, the facility failed to handle in-use oxygen containers

{S8030}

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE *Executive Director* (X6) DATE *1/4/24*

POC approved via phone call w/ executive director on 1/5/24 @ 4:13 PM

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| {S8030} | <p>Continued From page 1</p> <p>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 fourteen (14) of the resident rooms in the facility. The findings were:</p> <p>Observation on 10/11/2023 starting at 10:36 AM in room 118, revealed that the resident had less than 300 cubic feet of small oxygen cylinders stored in their room. It was further observed in multiple rooms throughout the facility. Additionally, it was noted that rooms 204, 206, 210, 306, 313, and 415 had oxygen placed freestanding. Oxygen storage containers must be secured against damage at all times.</p> <p>-CORRECTED- Observation during the revisit survey on 12/13/2023 starting at 10:55 AM revealed oxygen containers had been secured.</p> <p>3. Based on observation and staff interview, the facility failed to properly store oxygen, when over 300 cubic feet, in a storage area in accordance with the 2005 NFPA 99 Standard for Health Care Facilities. Failure to properly store oxygen could lead to injury or death during an emergency. The deficiency affected one (1) of multiple storage rooms. The findings were:</p> <p>Observation on 10/11/2023 at 10:58 AM in the secure unit storage room revealed: 15 E size cylinders, 2 A size cylinders, and 1 C size cylinder totaling approximately 375 cubic feet. Additionally, oxygen was stored next to a printer and printing supplies, on top of carpet. The room itself was general storage including combustible items. Oxygen was also stored directly next to an electrical outlet. The door of the storage room</p> | {S8030} | | |
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Healthcare Licensing and Surveys

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| {S8030} | <p>Continued From page 2</p> <p>failed to indicate that it was being used for oxygen storage. Oxygen storage in quantities greater than 300 cubic feet, but less than 3,000 cubic feet, must be within a dedicated space of noncombustible or limited-combustible construction.</p> <p>-CORRECTED- Observation during the revisit survey on 12/13/2023 at 11:03 AM revealed that there was less than 300 cubic feet of oxygen in the storage room and that a sign designating the room for oxygen storage had been placed.</p> <p>4. Based on observation and staff interview, the facility failed to maintain oxygen cylinder storage associated with patient rooms in accordance with the 2005 NFPA 99, Standard for Health Care Facilities. Failure to maintain oxygen storage in patient rooms as required could result in injury or death. The findings were:</p> <p>Observation during the revisit survey on 12/13/2023 at 10:55 AM at patient room 110 revealed sixteen (16) "A" size oxygen cylinders. Oxygen cylinders in patient rooms shall be limited to immediate use.</p> <p>Interview with the facility maintenance manager and facility administrator at the time of observation acknowledged the deficiency, and indicated they were not aware of the requirement.</p> <p>Interview with the facility administrator at the time of exit acknowledged the deficiency.</p> <p>Ref: 2005 NFPA 99 Ch. 9, Sec. 4.3.4</p> | {S8030} | | |

Edgewood -- Spring Wind

1072 N. 22nd St.

Laramie, WY 82072

Survey Date: December 13, 2023

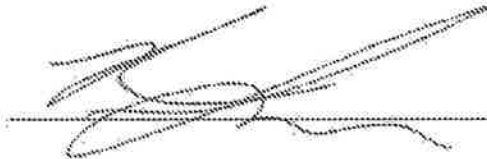
Ref: LH-2023-1293

Plan of Correction

Tag: S8030 -- NFPA Life Safety -Nfpa Miscellaneous

- A. The Environmental Service Director will ensure each resident room is equipped with self-closing door hinges and each door closes fully when dropped unassisted. This will ensure each room meets the 1 hour fire rating and should satisfy 2012 NFPA 99, 11.3.3 - 11.3.3.4.
- B. The Environmental Service Department will continue to work with the Clinical Service Department and O2 supply companies to ensure any oxygen stored and/or oxygen available for immediate use will not exceed 300 cubic feet.

Executive Director: _____



Date of completion: ~~1/25/2023~~ ²⁰²⁴ 

Date: 1/4/2024