Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALF004	A. BUILDING: ______ B. WING ______	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE ASSISTED LIVING COMMUNITY	1930 EAST 12 STREET CASPER, WY 82601

(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 05/14/2024 and 05/15/2024. The facility was a single story fully sprinklered building of Type V (111) construction built in 1987. The building was equipped with a supervised automatic wet sprinkler system, and an addressable fire alarm system. The facility had a capacity of 115 licensed beds with a census of 56 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		
S8012	NFPA Life Safety - Nfpa Emergency Lighting NFPA 101 Emergency Lighting This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency lighting in accordance with NFPA 101, Life Safety Code.	S8012		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 5/24/24

STATE FORM 6899 XK2Z11

PoC accepted via phone call w/ Admin on 5/24/24 @ 12:35 PM
[signature]

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S8012	Continued From page 1 Failure to maintain emergency lighting as required could result in injury or death during an emergency. The deficiency affected all residents, staff, and visitors in the facility. The findings were: Observation on 05/15/2024 at 9:01 AM adjacent to the west entrance revealed an emergency light that when tested, failed to operate. Interview with the executive director and maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the executive director at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101 Sections 22-3.2.9 and 5-9.1	S8012		
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 doors with self-closing devices in accordance with NFPA 101, Life Safety Code. Failure to maintain doors with self-closing devices as required could allow for the propagation of fire or smoke from a hazardous area resulting in injury or death during an emergency. The findings were: Observation on 5/15/24 at 8:50 AM at the dietary office/storage area revealed a door with a self-closing device. Further observation revealed the door was propped open with a door chock	S8015		

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	ALF004	A. BUILDING: ________ B. WING ________	05/15/2024

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S8015	Continued From page 2 hindering the devices operation. Doors to hazardous areas shall be self-closing or automatic-closing. Interview with the executive director and maintenance manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the executive director at the time of exit acknowledged the deficiency.	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 and/or maintain documentation of 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 findings were: Document review on 05/14/2024 starting at 3:20 PM revealed the facility had been conducting fire drills once per month, but had not been evacuating all residents to an assembly point as required. Interview with the executive director and maintenance manager at the time of observation	S8027		

Healthcare Licensing and Surveys

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	ALF004	A. BUILDING: ______ B. WING ______	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S8027	Continued From page 3 acknowledged the deficiency, and indicated they were not aware of the requirement. Interview with the executive director at the time of exit acknowledged the deficiency. Ref: 1994 NFPA 101 Sec 22.1.4, Sec 31.7.3 and WDH CH 12 rules (o)(iii)(E)	S8027		
S8030	NFPA Life Safety - Nfpa Miscellaneous NFPA 101 Miscellaneous This State Rule and Regulation is not met as evidenced by: Based on observation and staff interview, the facility failed to handle oxygen containers within resident rooms in accordance with NFPA 99, Standard for Health Care Facilities. Failure to appropriately handle in-use oxygen containers as required could result in injury or death. The findings were: Observation on 05/152024 at 9:58 AM AM at resident room 316 revealed a room with oxygen in use. Further observation revealed that the resident room stored more cylinders than "for immediate use"; approximately eight (8), M4 size cylinders were observed to be stored in the resident room. Additional observation in resident room 320 revealed approximately thirteen (13), E size cylinders. An individual cylinder placed in a patient care area for immediate use shall not be required to be stored in an enclosure. Interview with the executive director and maintenance manager at the time of observation acknowledged the deficiency, and indicated they	S8030		

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	ALF004	A. BUILDING: ______ B. WING ______	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S8030	Continued From page 4 were not aware of the requirement. Interview with the executive director at the time of exit acknowledged the deficiency. Ref: 1993 NFPA 99, Ch. 8-3.1.11 and 4-3.1.2.1(b)	S8030		

PLAN OF CORRECTION

FACILITY NAME: PARK PLACE ASSISTED LIVING COMMUNITY

SURVEY DATE: May 15, 2024

TAG: S8012

1. CORRECTIVE ACTION

The batteries for this emergency light were replaced on 5/23/2024. Monthly testing of all emergency lighting is scheduled in TELS and completed monthly. This testing had not been conducted for the month of May at the time of this survey.

2. IDENTIFICATION OF OTHERS AT RISK

All residents, staff and guests were put at risk.

3. SYSTEM MEASURES

Batteries have been replaced as of 5/23/2024.

4. MONITORING

Continue with monthly testing and documentation in TELS.

5. QA

All documentation for testing is signed off monthly in TELS. Will review quarterly during QA/Safety meetings to ensure compliance.

PLAN OF CORRECTION

FACILITY NAME: PARK PLACE ASSISTED LIVING COMMUNITY

SURVEY DATE: May 15, 2024

TAG: S8015

1. **CORRECTIVE ACTION**

A self-closing device was not present on this door. One has been installed to ensure compliance with this regulation.

2. **IDENTIFICATION OF OTHERS AT RISK**

All residents, staff and guests were put at risk.

3. **SYSTEM MEASURES**

A self-closing device was installed on the dining office/storage door on 5/21/2024. Signage has also been placed on this door that instructs staff to keep the door closed at all times.

4. **MONITORING**

Kitchen staff have been educated on the importance of keeping this door closed at all times, and have signed off acknowledging this training. Dining Services Director to ensure ongoing compliance with this expectation.

5. **QA**

Will monitor during weekly administrator kitchen walkthroughs. Will also review quarterly during QA/Safety meetings to ensure compliance.

PLAN OF CORRECTION

FACILITY NAME: PARK PLACE ASSISTED LIVING COMMUNITY

SURVEY DATE: May 15, 2024

TAG: S8027

1. CORRECTIVE ACTION

Facility fire plan has been updated to include full evacuation from the building during fire drills.

2. IDENTIFICATION OF OTHERS AT RISK

All residents put at risk.

3. SYSTEM MEASURES

The fire plan has been updated. All residents and staff will be educated on the new process by June 15, 2024. A full exit fire drill will be performed by June 30, 2024 and then monthly thereafter.

4. MONITORING

Monthly fire drills are documented in TELS to ensure compliance. Fire drills will be timed and graded at the end of each drill by the Maintenance Director and Executive Director. Executive Director will audit drills to ensure full resident evacuation, timeliness, and correct documentation in TELS monthly for 3 months.

5. QA

Will discuss quarterly at QA/Safety meetings to ensure ongoing compliance.

PLAN OF CORRECTION

FACILITY NAME: PARK PLACE ASSISTED LIVING COMMUNITY

SURVEY DATE: May 15, 2024

TAG: S8030

1. **CORRECTIVE ACTION**

Maintenance Director and Executive Director relocated excess oxygen containers for apartments #316 and #320 to a non-combustible 1-hour fire rated storage room on 5/21/2024.

2. **IDENTIFICATION OF OTHERS AT RISK**

All residents, staff and guests put at risk.

3. **SYSTEM MEASURES**

Oxygen for immediate use will be kept in these resident apartments. All excess oxygen containers will be stored in the 1-hour fire rated storage room. Nursing staff has been educated on this process and Lincare delivery will now drop off and pick up oxygen cylinders from this storage room.

4. **MONITORING**

ED and/or ESD will audit on hand oxygen and oxygen storage is being stored correctly once weekly for 4 weeks, monthly for 3 months.

5. **QA**

This will be reviewed quarterly during safety/QA meetings to ensure compliance.