DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR 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) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered single story building of Type V (111) construction built in 1967 and additional plan approval in 1973. The building was equipped with a supervised automatic wet sprinkler system with an antifreeze branch and a newly installed addressable fire alarm system. The facility had a capacity of 120 certified medicare and medicaid beds.	K 000	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law." This plan of correction is the facility's credible allegation of compliance.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all smoke barriers were maintained as a continuous membrane in 3 of 5 smoke compartments. The findings were: Observation on 9/22/11 between 11 AM and 3:00 PM revealed the following concerns: 1. A 2-inch x 4-inch hole was noted in the wall in the main medication room behind the nurses' station. In addition, in this same room was noted a 3-inch circular hole in the ceiling. 2. A 12-inch x 12-inch hole was noted in the ceiling of the bathroom in resident room #507.	K 012	K012 It is the practice of the facility to ensure that the building is well maintained and maintenance issue are quickly address. Corrective Action 1. Identified hole in wall was plugged with ⅝ inch fire retardant sheet rock and sealed with fire retardant caulking. 2. Identified hole in ceiling was plugged with ⅝ inch fire retardant sheet rock and sealed with fire retardant caulking. 3. Identified missing drywall was replaced with ⅝ inch fire retardant sheet rock and sealed with fire retardant caulking.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQPS11 Facility ID: WY0033 If continuation sheet Page 1 of 9

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Wyoming Dept of Health
OCT 1 5 2011
Office of Healthcare Licensing and Surveys

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Wyoming Dept of Health
OCT 2 7 2011
Office of Healthcare Licensing and Surveys

Approved without need to change on 10/26/11 @ 5pm. Notified facility 10/27/11 @ 930 Am

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K 012	Continued From page 1 3. An approximate two square foot piece of drywall was missing in the resident bathing room in hall 6. 4. The maintenance manager verified these findings at the times of the observations. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor. Such firestopping shall consist of wood not less than 2 in. (5 cm) (nominal) thick or shall be of noncombustible material. 19.3.6.2.2 Corridor walls and ceilings shall form a barrier to limit the transfer of smoke.	K 012	Identification of Others Maintenance Director conducted audit to identify other possible issues with drywall in the facility. Systemic Changes Maintenance Director will educate his staff to repair identified holes in drywall according to Life Safety Code. Maintenance Director and Assistant will audit facility monthly to identify any new holes in drywall and repair according to schedule. Monitoring Maintenance Director will conduct follow-up inspection of all drywall repairs to ensure compliance. Maintenance Director will report results of holes audit to facility QA&A Committee monthly. Date of Correction On or before November 3, 2011	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 It is the practice of the facility to ensure that the building is well maintained and maintenance issue are quickly address. Corrective Action 1. Identified resident room door was adjusted to close with less than 5 foot-pounds of pressure. 2. Identified self-closure device was repaired by replacing the operating arm.	

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 corridor doors were resistant to the passage of smoke in 2 of 8 smoke compartments. The findings were: Observation on 9/22/11 between 11 AM and 3:30 PM revealed the following concerns: 1. The corridor door to resident room #402 did not close completely in its frame unless force in excess of 5 foot pounds of pressure was applied. 2. The staff lunch room by the nurses' station had a disabled self-closure device (SCD) attached to the door. The maintenance manager stated the room at one time was used as a copy room and had a SCD attached to the door. However, the SCD had been disabled. 3. The maintenance manager verified the above findings at the times of the observations. Reference: NFPA 101, Life Safety Code, 2000 edition Section 19.3.6.3 Corridor Doors. In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.1. Gasketing of doors should not be necessary to achieve resistance to the passage of smoke if the door is relatively tight-fitting	K 018	Identification of Others Maintenance Director conducted audit of all resident doors to ensure closure with less than 5 foot-pounds of pressure. Maintenance Director conducted audit of all doors using self-closure devices to ensure proper function. Systemic Changes Maintenance Director or Assistant will conduct weekly audits of all resident room doors to ensure closure at less than 5 foot-pounds of pressure. Maintenance Director or Assistant will conduct weekly audits of all doors with self-closure devices to ensure proper function. Monitoring Maintenance Director will report audit result weekly to the TELS QA&A program. Date of Correction On or before November 3, 2011	

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K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 smoke barrier door was resistant the passage of smoke in 1 of 8 smoke compartments. The findings were: Observation on 9/22/11 at 12:46 PM revealed the smoke barrier doors leading into the dining room had maglocks attached. However, upon release of the doors, one of the doors was unable to close because the bottom of the door was in contact with the floor. The maintenance manager confirmed the finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self closing or automatic closing in accordance with 19.2.2.2.6.	K 027	K027 It is the practice of the facility to ensure that the building is complaint with Fire Code. Corrective Action 1. Identified door was adjusted to ensure easy closure. Identification of Others Maintenance Director conducted audit to identify any other fire doors that do not close easily due to length of door. Systemic Changes Maintenance Director or Assistant will conduct weekly audits of all fire doors to ensure proper closure. Monitoring Maintenance Director will report audit result weekly to the TELS QA&A program. Date of Correction On or before November 3, 2011	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 4 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 doors with self closure devices were operating properly in 2 of 8 smoke compartments. The findings were: Observation on 9/22/11 at 10:18 AM revealed the oxygen auxiliary room had a self-closure device (SCD) attached. However, the door did not latch into its frame with three separate attempts. In addition, the resident's bathing room in hall 6 had a SCD attached to the door; however, the door did not shut upon three attempts. Interview with the maintenance manager at the time of the observation confirmed the findings. Reference: NFPA 101, Life Safety Code, 2000 Edition. 7.2.1.8.1 Self Closing Devices. A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing in accordance with 7.2.1.8.2.	K 029	K029 It is the practice of the facility to ensure that the building is well maintained and maintenance issue are quickly address. Corrective Action 1. The strikers on the identified doors were adjusted to allow for proper latching. Identification of Others Maintenance Director conducted audit to identify any other door latching devices that were not closing properly. Systemic Changes Maintenance Director or Assistant will conduct weekly audits of all latching doors to ensure proper closure. Monitoring Maintenance Director will report audit result weekly to the TELS QA&A program. Date of Correction On or before November 3, 2011	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056 SS=D	Continued From page 5 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinkler heads in 2 of 8 smoke compartments were installed as required. The findings were: Observation on 9/22/11 between 11 AM and 3:30 PM revealed the following concerns: 1. A ventilation duct was blocking the sprinkler head spray pattern in the housekeeping closet in the 100 hall. 2. A ceiling mounted expansion tank was blocking the sprinkler head spray pattern in boiler room number #1. 3. Interview with the maintenance manager at the time of the observations confirmed the findings. Reference: NFPA 101, Life Safety Code, 2000 edition.	K 056	K056 It is the practice of the facility to ensure that the building is complaint with Fire Code. Corrective Action 1.The supply pipe to the identified sprinkler head was lengthened by Frontline Fire to ensure proper spray pattern. 2. The supply pipe to the identified sprinkler head was lengthened by Frontline Fire to ensure proper spray pattern. Identification of Others Maintenance Director conducted audit to identify any other non-compliant sprinkler heads that might need lengthening. Systemic Changes Frontline Fire will conduct audit quarterly to ensure proper spray patterns for all sprinkler heads. Monitoring Maintenance Director will report audit result quarterly to the TELS QA&A program. Date of Correction On or before November 3, 2011	

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K 056	Continued From page 6 5-6.5.3 Obstructions that prevents 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.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the fire suppression (sprinkler) system was properly maintained in 1 of 8 smoke compartments. The findings were: Observation on 9/22/11 at 2:48 PM revealed revealed a gap greater than one-half inch existed between the sprinkler head escutcheons and the ceiling in the therapy room and on the wall in resident room #501. Interview with the maintenance manager at the above time confirmed the observation. Reference: NFPA 25 Standard for the Inspection, Testing, and Maintenance of the Water-Based Fire Protection systems, 1992 edition. 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign material, paint, and physical damage and shall be installed in the proper	K 062	K.062 It is the practice of the facility to ensure that the building is complaint with Fire Code. Corrective Action 1. Maintenance Staff adjusted the identified escutcheons according to code. Identification of Others Maintenance Director conducted audit to identify any other escutcheons that needed adjustment. Systemic Changes Frontline Fire will conduct audit quarterly to ensure proper adjustment of all escutcheons. Monitoring Maintenance Director will report audit results quarterly to the TELS QA&A program. Date of Correction On or before November 3, 2011	

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K 062	Continued From page 7 orientation (e.g., upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to maintain access to all portable fire extinguisher in 1 of 8 smoke compartments. The findings were; Observation on 9/22/11 at 1:48 PM revealed a wall mounted, portable fire extinguisher (ABC type) in the special care unit. The handle on the case enclosing the extinguisher was missing and prevented the door from being opened. Interview with the maintenance manager at the above time confirmed the observation. Reference: NFPA 10, Standard for the Installation of Portable Fire Extinguishers, 1990 edition, 1-6.3. Extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire.	K 064	K064 It is the practice of the facility to ensure that the building is complaint with Fire Code. Corrective Action 1. Identified fire extinguisher door handle was replaced. Identification of Others Maintenance Director conducted audit to identify any other missing fire extinguisher door handles. Systemic Changes Maintenance Director or Assistant will conduct audit monthly to ensure fire extinguisher door handles are in good repair. Casper Fire will conduct quarterly audit of fire extinguisher door handle. Monitoring Maintenance Director will report audit results monthly and quarterly to the TELS QA&A program.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	Date of Correction On or before November 3, 2011	

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K 147	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with the National Electric Code in 2 of 8 smoke compartments. The findings were: Observation on 9/22/11 at 2:30 PM revealed an extension cord was being used in the auxiliary dining room. Attached to the cord was a swamp cooler. In addition, a light switch in the utility room in the 400 hall was missing a cover. Interview with the maintenance manager at the time of the observation confirmed the findings. Reference: NFPA 70, National Electrical Code, 1999 Edition. 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure.	K 147	K147 It is the practice of the facility to ensure that the building in compliance with Life Safety code Corrective Action 1. Identified extension cord was replaced with a power strip according to code. 2. Identified light switch cover was replaced. Identification of Others Maintenance Director conducted audit to identify any extension cords not in use. Maintenance Director conducted audit to identify any missing light switch covers. Systemic Changes Maintenance Director or Assistant will conduct audit monthly to ensure extension cords are not in use. Maintenance Director or Assistant will conduct monthly audit to ensure all light switches are properly covered. Monitoring Maintenance Director will report audit results monthly to the TELS QA&A program. Date of Correction On or before November 3, 2011	