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 _____	03/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST CASPER, WY 82601

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K 000	INITIAL COMMENTS	K 000	ADDITIONS & ACCEPTANCE OF THIS POC WITH ARLOA JOHNSON, NHA, ON 4/10/06 & 4/13/06 VIA TELICONFERENCE & ADDITION REQUEST LETTER.	
	Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a complete supervised automatic wet sprinkler system and a anti-freeze branch under the canopy to the kitchen. K6: Date of Plan Approval: 1967, 1973 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=120;SNF/NF=120 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association			
K 018 SS=E	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	1. Roller latches will be removed from the dining room and the sunflower room door to meet NFPA 101 requirements. A magnetic release with door self-closing devices, wired into the current fire alarm system, will be installed. The maintenance Supervisor (MS) will review new NFPA regulations and advise the administrator as to any changes that are not grand -fathered.	4-24-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arloa M Johnson — TITLE: — (X6) DATE: 3-31-06

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.

APR 04 2006

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. On 03/07/06 between 9:07 AM and 11:20 AM observation revealed the following corridor doors had gaps greater than the allowed 1/8 th of an inch between the top edge of the doors and the door frames. a. Resident room #101 b. Resident room #104 c. MDS Office d. Resident room #108 e. Resident room #412 f. Resident room #601 g. Resident room #608 h. Resident room #606 i. Resident room #204 2. On 03/07/06 at 10:31 AM observation revealed the corridor door to resident room #513 had a bolt which would not insert into the strike plate of the door frame, preventing the door from latching. 3. On 03/07/06 at 10:15 AM observation revealed the telephone room door to the courtyard was impeded by a chair.	K 018	1&2. The M.S. will continue to inspect facility doors monthly and correct or adjust as needed. The M.S. will report to the QAA committee as to his findings X3 months. 3. The M.S. will in-service facility employees as to the fact that no doors will be propped open. The M.S. will report to the facility Safety Committee monthly X3 months.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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K 029	Continued From page 2 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 observations, the facility failed to separate 2 of 15 hazardous areas from other spaces in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. On 03/07/06 at 9:41 AM observation revealed the copy room was larger than 50 square feet, had shelving units filled with paper, and the corridor door did not have a self-closing device. 2. On 03/07/06 at 10:22 AM observation revealed the housekeeping office was larger than 50 square feet, had shelving units filled with blankets and bed sheets, and the corridor doors did not have self-closing devices.	K 029	1 & 2. As outlined in NFPA 101, 19.3.2.1, the copy/fax room and the housekeeping office, as deemed hazardous areas by the authority having jurisdiction, will have self-closing devices installed. The M.S. will insure that all self-closing devices function properly and report to the QA&A committee monthly X3 months.	4-24-06
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided	K 051	1. Annual testing of the heat detectors will be documented by the establishment of a form to be maintained by the M.S. and filed with all other fire alarm systems test records. All fire alarm test records will be reviewed by the QA&A committee monthly X3 months.	4-24-06 FIRE.

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K 051	Continued From page 3 that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		
	This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to test the installed fire alarm system in accordance with NFPA 72 Table 7-3.2. The finding was: 1. Review of the maintenance fire alarm testing records revealed the heat detectors had not been tested in the past 12 months as required by the Code. The facility contacted the testing company and maintenance staff interview on 3/7/06 at 8:36 AM confirmed the testing had not occurred.			
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 056	1. The M.S. will contact at least two qualified sprinkler system installation companies and:	

3/31/06

See Attached 1 Request for time extension

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K 056	Continued From page 4 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 observations, the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1, 5-13.8.1, 5-6.3.3, and 5-6.3.2.1 respectively. The findings were: 1. On 03/07/06 between 9:31 AM and 11:17 AM the following exterior structures were observed and determined not to be constructed of non-combustible or limited combustible material. The canopies were wider than 4 feet and did not have sprinkler coverage: a. The roof was constructed of pine rafters and plywood sheathing. b. The canopy over hall #1 exit. c. The canopy over hall #4 exit. d. The canopy over hall #5 exit. e. The canopy over hall #6 exit. f. The 15 eves over all the exterior windows for resident rooms on hall #5 and hall #6. 2. On 03/07/06 at 9:56 AM, one of four sprinkler heads in the activities room was less than the allowed 4 inches from the wall. 3. On 03/07/06 at 9:58 AM, one of four sprinkler heads in the activities room was more than the allowed 7 1/2 feet from the end wall. The sprinkler was 10 feet from the end wall.	K 056	a. Solicit plans to install twenty-four additional heads by 3-31-06. b. Forward to the Department of Health the aforementioned plans on or before 5-15-06. c. Submit for construction approval within 45 days of plan acceptance by the Department of Health. TENTATIVE DATE 7/1/06 d. Submit for final inspection by the Department of Health within 30 days of construction approval. TENTATIVE DATE 8/1/06 2. Item 2 & 3 will be corrected to meet NFPA by moving the aforementioned sprinkler head as required. The M.S. will inspect the facility to insure there are not other sprinkler heads that do not meet this requirement. These two sprinkler heads will be corrected at the same time as item 1 above. A SECOND TEMPORARY WAIVER WILL BE SUBMITTED FOR APPROVAL.	

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K 062	Continued From page 5	K 062		
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 observations, the facility failed to maintain the installed sprinkler system in accordance with NFPA 13 Section 5-6.5.3 and NFPA 25 Section 2-2.1.1, respectively. The findings were: 1. On 03/07/06 at 12:10 PM observation revealed several of the sprinkler heads in the attic crawl space above hall #3 had insulation falling down from the rafters onto the sprinkler heads obstructing their spray patterns. 2. On 03/07/06 at 9:37 AM, two of two sprinkler heads in the dish room were visibly corroded.	K 062	1. Attic insulation will be inspected monthly to insure that insulation has not obstructed sprinkler head spray. The M.S. will report his findings to the safety committee X3 months. 2. The M.S. will replace two of two sprinkler heads in the dish room and monitor this area for further concerns X3 months.	4-24-06
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under	K 066		

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K 066	Continued From page 6 direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to adopt smoking regulations in accordance with NFPA 101 Section 19.7.4. The findings were: 1. On 03/07/06 at 10:11 AM observation revealed the resident smoking area in the courtyard near the telephone room had numerous cigarette butts on the ground mixed with dry leaves. It could not be determined if the provided ashtrays were of a safe design or if residents who smoked were under direct supervision.	K 066	1. Residents who smoke are under direct supervision as indicated by the attached activity records. Further investigation indicates that the cigarette butts in the question are as a result of high winds and or wheelchairs tipping the ashtrays over, spilling the contents. The M.S. will secure ashtrays to keep them from tipping over. The housekeeping department will clean the ashtrays two (2) times daily to reduce cigarette butt build- up. Cigarette butts/ dried leaves will be removed as needed. The M.S. will report his findings to the QA&A committee monthly X3 months.	4-24-06 See attached #243