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 _____	11/17/2010

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 this 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 (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1967 and 1973. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and a newly installed addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 111 residents.	K 000		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure non-exit exterior doors were properly marked in 1 of 8 smoke compartments. The findings were:	K 022	K22 1. Purchase and install "NO EXIT" signs for affected doors. 2. There are no other instances of this in our facility 3. Monitor weekly to insure sign compliance 4. Present plan to monthly QA&A for IDT notification and compliance. 5. Correction date on or before 12/31/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/13/10

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.

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Wyoming Dept of Health
DEC 14 2010

PLC ACCEPTED W/ DEMS FOUND, MH, DD 12/21/10

Office of Healthcare Licensing and Surveys

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K 022	Continued From page 1 Observation of the egress system on 11/17/10 at 11:17 AM showed the glass courtyard door near the front nurses' station was not marked with a NO EXIT sign. At the time of observation the maintenance manager reported he was not aware of the requirement.	K 022		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 8 smoke barrier walls were smoke resistant. The findings were: Observation of the attic smoke barrier wall near resident room #217 on 11/17/10 at 4:40 PM showed there was one unsealed penetration. The penetration was a 1-inch circular hole. At the time of observation the maintenance manager reported the attic barriers were not routinely inspected to ensure they were smoke resistant.	K 025	K.025 1. Hole will be caulked with fire retardant caulk at site reported. 2. Maintenance Dir. or designee will inspect entire facility to ensure compliance in all areas. 3. Monthly inspection done by Maint. Dir. or designee to maintain compliance. 4. Report compliance to monthly QA&A to insure IDT notification and continued compliance. 5. Correction date on or before 12/31/10	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single	K 045		

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K 045	Continued From page 2 lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit discharge lighting fixtures had two bulbs illuminated at 1 of 8 exits. The findings were: Observation of the exterior exit discharge lights on 11/16/10 at 6:30 PM showed one of two light bulbs on the 600 wing were not illuminated. On 11/16/10 at 12:10 PM the maintenance manager reported the lights were inspected at least on a weekly basis. Furthermore, he reported the lights were frequently noted to be burned out upon inspection.	K 045	K045 1. Burned out bulbs have been and will be replaced. 2. Inspect facility for any bulbs in these signs that need replacing and replace. 3. Maintenance Dir. or designee will inspect all exit signs weekly for proper functioning and repair as necessary. 4. Maintenance Dir. will report to monthly QA&A on weekly inspections to monitor compliance. 5. Correction date on or before 12/31/10.	
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure light bulbs in exit signs were illuminated in 1 of 8 smoke compartments. The findings were: Observation of the 100 hall exit signs on 11/17/10 at 4:50 PM showed the sign near resident room	K 047	K047 1. Burned out bulbs outside rooms 102 and 115 replaced immediately. 2. Facility will be inspected to make sure all bulbs in exit signs functioning and repair as necessary. 3. Maint. Dir or designee will perform weekly inspection to make sure all bulbs are functioning properly. 4. Maint. Dir. will report monthly to QA&A to monitor compliance of weekly inspections. 5. Correction date on or before 12/31/10.	

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K 047	Continued From page 3 #102 and #115 both had 1 of 2 bulbs that were not illuminated. At the time of observation the maintenance manger reported he was aware both bulbs were required to be illuminated at all times. He further reported all exit signs were inspected on a weekly basis. He state he was not sure why the lights had not been replaced.	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure fire drills were held on a quarterly basis for 2 of 3 shifts. The findings were: Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM, the second shift occurred between 2 PM and 10 PM, and the third shift occurred between 10 PM and 6 AM. Further review documented a fire drill had not been conducted on the first shift during the third quarters of 2010. Records also documented a fire drill had not been conducted on the third shift during the second quarter of 2010. On 11/17/10 at 3:20 PM the maintenance manager reported he was aware of the fire drill testing requirement. He further reported there were no	K 050	K050 1. Facility will follow required fire drill regulations. 2. Maint. Dir. will monthly hold fire drills on the appropriate shifts and document participation and results 3. Maintenance Dir. will present up coming drills to administrator to insure compliance. 4. Maint. Dir will report monthly to QA&A detailing fire drill times and outcomes to the IDT. 5. Correction date on or before 12/31/10.	

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K 050	Continued From page 4 other records to review. He also reported the missed drills were the responsibility of the previous maintenance manager.	K 050		
K 062 SS=E	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 observation, record review, and staff interview the facility failed to ensure sprinklers were unobstructed and free of corrosion in 3 of 8 smoke compartments. The findings were: 1. Observation of the sprinkler system on 11/17/10 between 9 AM and 12 PM showed the sprinkler head in the kitchen pantry hallway and at the special care unit nurses' station were obstructed by ceiling mounted lights. The lights were installed within 12 inches of the sprinkler heads and the lights were below the bottom of the sprinkler deflectors. At 11:22 AM the maintenance manager reported the above mentioned lights were replaced 3 months ago by the previous manager. Review of the last sprinkler system inspection report completed on 10/12/10 showed the contractor had noted the same obstructed sprinkler heads. At 3:20 PM the maintenance manager reported he had not noticed the comments on the inspection report and had not made plans to modify the noted locations. 2. Observation of the sprinkler system on	K 062	K062 1. Vendor contacted and replacement/repair of affected sprinkler heads in progress. Lighting fixtures will be moved at time of replacement of heads. 2. Inspection of all sprinkler heads to insure none are corroded. Also inspection of their placement to light fixtures. 3. Maint. Dir or designee will perform monthly inspection to check for corrosion. 4. Maint. Dir. will report monthly to QA&A for continued compliance. 5. Correction date on or before 12/31/10.	

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FORM APPROVED
OMB NO. 0938-0391

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

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K 062	Continued From page 5 11/17/10 at 1:20 PM showed the sprinkler head in the 200 wing shower room was corroded. At the time of observation the maintenance manager confirmed the head was corroded. He further reported that he was not aware that corroded heads were required to be replaced.	K 062		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the ventilation system was maintained in 1 of 8 smoke compartments. The findings were: Observation of the ventilation system on 11/17/10 between 10 AM and 5 PM showed the ventilation system was no longer in service. At 10:33 AM the newly installed smoke detector in resident room #312 was installed closer than 36 inches from the ventilation diffuser. Further review showed 12 of 12 resident rooms had the same configuration with each diffuser tightly closed. Inspection of the 300 hall attic space showed the ventilation system was originally installed with 10-inch circular fiberglass duct work, but every duct was flattened and had been abandoned in the attic. At the exit conference the administrator reported he was not aware that a ventilation system was required to be maintained as originally installed.	K 067	K067 1. Immediate contact made to vendor to assess ventilation in entire facility. 2. Vendor inspection and proposal od scope of work for ventilation system in Halls 1, 2, 3, 4. Final plans to be presented to state engineering department for approval. 3. Once plans approved, correction of facility ventilation system will begin. Upon completion, state engineering department will be contacted for approval. 4. After completion and approval, monthly checks will be completed by Maintenance Director/designee to insure proper working order. Report will be presented to monthly QA&A. 5. Plans for correction will be submitted to state engineering by 1/15/11. - Approval by 3/15/11 - Vendor contacted and work completed by 4/20/11 - Final approval by state engineering by 6/20/11.	
K 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		

Dennis Bofinger 12/22/10

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K 074 SS=E	Continued From page 6 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure window curtains were flame retardant in 1 of 8 smoke compartments. The findings were: Observation of the window curtains in the special care unit medication room on 11/17/10 at 11:32 AM showed they did not have flame retardant documentation attached to them. At the time of observation the maintenance manager reported he did not have any flame retardant records to review for these curtains.	K 074	K074 1. Apply appropriate fire retardant treatment on affected curtain for compliance. 2. Inspect all curtains to insure fire rated compliance. 3. Maint. Dir. or designee will inspect all curtains monthly to insure fire rated compliance. 4. Maint. Dir. will report monthly to QA&A to monitor compliance. 5. Correction date on or before 12/31/10.	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 143		

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K 143	Continued From page 7 Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure safety equipment was provided at 1 of 2 transfilling of liquid rooms. The findings were: Observation of the 600 wing liquid oxygen transfilling room on 11/17/10 at 11:49 AM showed a protective face shield was provided, but the plexiglas shield was missing from the visor. At the time of observation the maintenance manager reported he was not aware of the safety equipment requirement. He further reported the transfilling rooms were not routinely inspected.	K 143	1. Proper equipment acquired from vendor and in place for use. 2. All O2 rooms checked to for ~~face shield~~ compliance. 3. Maint. Dir. or designee will check O2 rooms weekly to insure that face shields are present. 4. Maint. Dir. will report monthly to QA&A to monitor for continued compliance. 5. Correction date on or before 12/31/10.	SAFETY EQUIPMENT