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WY Dept of Health
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Healthcare Licensing and Surveys

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

PRINTED: 11/01/2012
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	B. WING 01	10/16/2012

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 sprinkled single story building of Type V (111) construction built in 1967 and 1973. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 103.	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. K025 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 gap in 300 hall smoke barrier was sealed with Fire Barrier Sealant. Identification of Others Environmental Services Director/ Designee conducted audit to identify other possible gaps in smoke barrier. Systemic Changes Environmental Services Director /Designee will follow the TELS preventive maintenance program and perform quarterly audit to identify any gaps in smoke barriers and repair immediately In addition, EVS Director and Staff will inspect barrier following installation of new cable,	
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 was smoke resistant. The findings were:	K 025		

IORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Teresa J. Ralph — Interim Administrator — 11/9/2012

' deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lwing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

FOC ACCEPTED W/ TERESA RALPH, INTERIM NHA, ON 11/21/12.

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11/29/12

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K 025	Continued From page 1 Observation of the 300 hall smoke barrier on 10/16/12 at 1:47 PM showed one unsealed cable penetration. The gap measured ½ inch across. At the time of the observation the environmental services director reported the barrier walls were only inspected annually.	K 025	etc. by outside vendors to ensure no gaps in barrier were created. Monitoring Environmental Services Director will report results of smoke barrier audit to facility Safety Committee according to TELS schedule.	11/30/2012
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour 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 hazardous areas were separated from use areas in 1 of 8 smoke compartments. The findings were: Observation of the health information office on 10/16/12 at 11:12 AM showed there were 16 cardboard file boxes in the room. Further observation showed the corridor door was not equipped with a self-closing device. At the time of the observation the environmental service director reported she was unaware rooms with this amount of combustible storage required self-closing devices.	K 029	K029 It is the practice of the facility to ensure that a self-closing door separates hazardous areas from use areas. Corrective Action 1. Identified corridor door was equipped with a self-closing device. Identification of Others Environmental Services Director/ Designee conducted audit to identify rooms requiring self-closure doors. Systemic Changes Environmental Services Director /Designee will audit facility according to TELS schedule to identify any new area requiring a self-closing corridor door and install closure as needed. In future, an office move will trigger an audit for the necessity of a self-closure door. If EVS Director/Designee deems door closure necessary, one will be installed before room move takes place.	

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K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure 2 of 2 emergency battery light tests were performed, failed to ensure the generator had an annunciator panel and failed to ensure the emergency battery light was operational. The findings were: 1. Interview with the environmental services director on 10/16/12 at 1:55 PM confirmed the egress corridor lights were supplied with power from the emergency generator. Observation on 10/16/12 at 1:57 PM showed the generator was not equipped with an annunciator panel or remote indicator of any kind. At the time of the observation the environmental service director was unaware of the aforementioned requirement. 2. Review of the emergency battery light testing records showed the facility did not have a record of the last time the monthly 30 second or annual 90 minute tests were completed. On 10/16/12 at 2:50 PM the environmental service director reported she was unaware of the aforementioned tests. 3. Observation of the emergency battery light on 10/16/12 at 2:55 PM showed the light would not illuminate when the test button was depressed. At the time of the observation the environmental services director was unaware of the battery lights location, or of the testing requirement. None	K 046	Monitoring Environmental Services Director will report results of self-closing corridor door audit to the Safety Committee. K046 It is the practice of the facility to ensure that emergency lighting is provided for at least one and half-hour duration. Corrective Action 1. Generator will be equipped with an annunciator panel and emergency stop button. Parts for project will arrive at facility week of November 20th. Request for time limited wavier sent to the Dept. of Health on 11/20/12. Wavier stated that plan for installation of annunciator panel and emergency stop button will be submitted by 11/30/12. Work will begin no later than 12/15/12 pending approval from HLS Office. Completion of project will occur no later than 1/15/2013. 2. Annual 90-minute test of generator conducted per TELS schedule. 3. Battery operator light has been replaced. Identification of Others Inspection of Generator conducted by outside vendor to ensure it is well maintained and functioning properly.	11/30/2012

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K 046	Continued From page 3 of the maintenance staff were aware of the lights location either. Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1-1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 3-5.6.1 A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2 (d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel.	K 046	Monitoring Results of generator test, battery light audits and staff annunciator light education will be reported to the Safety Committee. K050 It is the practice of the facility to conduct fire drills at least quarterly on each shift. Corrective Action 1. Fire Drill was conducted on all three shifts to ensure staff followed proper procedure. Staff education conducted following each drill to ensure understanding of process. Identification of Others Environmental Services Director/ Designee conducted random audit of staff on all shifts to determine understanding of fire drill procedure. Systemic Changes Fire drill education will be conducted in "all staff" meetings at least quarterly and in new employee orientation as needed. Monitoring Environmental Services Director will report results of fire drills in Safety Committee meetings each month.	11/30/2012 11/30/2012
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	K 050		

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K 050	Continued From page 4 alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure fire drills were held on a quarterly basis during 3 of 3 shifts and failed to ensure staff members were familiar with required procedures on 1 of 3 shifts. The findings were: 1. Review of the fire drill testing records showed the first shift occurred between 6 AM and 2 PM, the second shift between 2 PM and 10 PM and the third shift between 10 PM and 6 AM. Further review showed a fire drill had not been conducted on the first shift during the fourth quarter of 2011 and the second quarter of 2012. A fire drill had not been held on the second shift during the third quarter of 2012. A fire drill had not been held on the third shift during the first, second and third quarters of 2012. On 10/16/12 at 2:50 PM the environmental service director could not explain why the previous director had not conducted fire drills on each shift on a quarterly basis. 2. Observation of the fire drill on 10/16/12 at 3:20 PM showed the first responder (Registered Nurse #1) used a phone to announce "Code Red" over the intercom system. The fire alarm system was not activated for three minutes until the maintenance staff activated the system. On 10/16/12 at 3:30 PM RN #1 reported he was aware the fire alarm system needed to be activated, but was nervous and started to close resident room doors. At 3:34 PM the director of nurses could not explain why the alarm was not	K 050		

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K 050	Continued From page 5 activated by any other nursing staff.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 2 of 10 fire alarm system components were tested. The findings were: 1. Review of the fire alarm system testing records showed the system was last tested on 12/6/11. Further review showed the semi-annual load voltage test had not been performed on the batteries in the fire alarm control panel in the past six months. On 10/16/12 at 2:50 PM the environmental services director was unaware of the aforementioned test. 2. Review of the fire alarm system testing records showed the system receiver had not been tested during the months of May and June 2012. On 10/16/12 at 2:50 PM the environmental services director was unaware of the aforementioned test.	K 052	K052 It is the practice of the facility to conduct fire alarm system testing. Corrective Action 1. Environmental Services Director /Designee conducted test of the semi-annual load voltage. 2. Environmental Services Director /Designee conducted test of the fire alarm system receiver, MONTHLY Identification of Others ~~Environmental Services Director /Designee also tested Ansul Fire Alarm System in the Kitchen to ensure proper function.~~ Systemic Changes Environmental Services Director /Designee will conduct annual Fire Alarm Charge Test, Annual Fire Alarm Discharge Test and Semi-Annual Load Voltage Test according to TELS schedule. Monitoring Environmental Services Director will report results of fire alarm testing in Safety Committee meetings according to schedule.	11/30/2012

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K 052	Continued From page 6 Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test,.....annually (Replace batteries every 4 years.) 2. Discharge Test ... ...annually (30 minutes) 3. Load Voltage Test,.....semi-annually	K 052	K062 It is the practice of the facility to ensure sprinklers are properly maintained and in reliable operating condition. Corrective Action 1. Sprinkler heads in the special care unit dining room will be replaced with sprinkler heads of the same type, temperature rating and classification. 2. Sprinkler heads in the dishwashing room will be replaced with sprinkler heads of the same type, temperature rating and classification. 3. Sprinkler head in the walk-in freezer will be replaced and maintained. Identification of Others Environmental Services Director/ Designee conducted an audit of facility sprinkler heads to ensure that each smoke compartment has sprinkler heads of the same type, temperature rating and classification. Systemic Changes Environmental Services Director /Designee will conduct an audit according to the TELS schedule of facility sprinkler heads to ensure that all smoke compartment sprinkler heads are well maintained and that replacement sprinklers are of the same type, temperature rating and classification as remaining sprinkler heads.	
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 observation and staff interview, the facility failed to ensure sprinklers were properly maintained in 3 of 8 smoke compartments. The findings were: 1. Observation of the special care unit dining room on 10/16/12 at 10:04 AM showed 3 of 17 heads were of different types. Further review on 10/16/12 at 10:59 AM showed the two sprinkler heads in resident room #106 were of different types. On 10/16/12 at 10:04 AM the environmental service director could not explain what the temperature rating and classification (standard, residential, fast-response) was for each head. She could not explain if all the heads would work as a system or if one head would activate early and delay or cold solder the other	K 062		

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K 062	Continued From page 7 heads. 2. Observation of the dish washing room on 10/16/12 at 11:19 AM showed both heads were corroded. At the time of the observation the environmental services director reported the heads were inspected annually by an outside contractor. The last sprinkler inspection report dated 9/21/12 did not indicate any heads were corroded. 3. Observation of the walk-in freezer on 10/16/12 at 11:21 AM showed a side wall sprinkler head was installed over the door. Further observation showed the sprinkler deflector was missing with the side arms bent. At the time of the observation the environmental services director reported the heads were inspected annually by an outside contractor. She was unaware when the sprinkler head was damaged. Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 5-1.1 The requirements for spacing, location, and position of sprinklers are based on the following principles: 1) Sprinklers installed throughout the premises 2) Sprinkler located so as not to exceed maximum protection area per sprinkler 3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution Reference, NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5 NFPA 25, 1998 Edition; 2-2.1.1* Sprinklers shall be visually inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the	K 062	Monitoring Environmental Services Director will report results of TELS audit in Safety Committee according to schedule..	11/30/2012

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K 062	Continued From page 8 proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged or loaded, or in the improper orientation.	K 062		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 on 10/16/12 between 8 AM and 9:30 AM showed the window curtains in the medication room and the director of nurses ' office did not	K 074	K074 It is the practice of the facility to ensure window curtains are flame retardant. Corrective Action 1. Window curtains without flame retardant documentation were removed from the medication room and the Director of Nursing office. Identification of Others Environmental Services Director / Designee conducted audit to identify and remove other window curtains that did not have flame retardant documentation. Systemic Changes Environmental Services Director /Designee will audit facility monthly to identify any window curtains that do not have flame retardant documentation. Curtains will be removed or treated with flame retardant solution. A log will be maintained of all window curtains to ensure they are flame retardant. Monitoring Environmental Services Director will report results of window curtain audit to facility Safety Committee monthly for 3 months.	11/30/2012

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	535024	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/16/2012

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

11/21/12

(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 074	Continued From page 9 have flame retardant documentation attached to them. On 10/16/12 at 8:27 AM the environmental services director reported she was unaware of any flame retardant log. She was also unaware of a log documenting that a flame retardant solution had been applied to any curtains.	K 074		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure soiled linen receptacles had adequate separation in 1 of 8 smoke compartments. The findings were: Observation of the 500 wing shower room on 10/16/12 at 9:46 AM showed two soiled linen carts were stored side by side. At the time of the observation the environmental services director reported she was unaware the receptacles required a separation of 8 square feet.	K 075	K075 It is the practice of the facility to ensure soiled linen and trash collection receptacles have adequate separation. Corrective Action 1. The soiled linen carts in the 500-wing shower room were removed and replaced with a receptacle meeting code requirements. Identification of Others Environmental Services Director / Designee conducted audit to identify and remove any receptacles not meeting code requirements. Systemic Changes Environmental Services Director /Designee will audit facility monthly to identify and remove any soiled linen receptacles that do not provide the required separation. Monitoring Environmental Services Director will report results of audit to facility Safety Committee monthly for 3 months.	11/30/2012
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 141		

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K 141	Continued From page 10 Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure rooms with oxygen in use were posted with " No Smoking " signs in 3 of 8 smoke compartments. The findings were: Observation on 10/16/12 between 8:30 AM and 11:30 AM showed resident room #413, #411, #505 and #107 had oxygen in use and the corridor doors were not posted with " No Smoking " signs. Further observation of the smoke compartment showed all other rooms with oxygen in use were posted as required. On 10/16/12 at 8:43 AM the environmental services director reported the " No Smoking " signs were supposed to be posted by the nursing staff.	K 141	K141 It is the practice of the facility to display non-smoking and no smoking signs in areas where oxygen is used or stored. Corrective Action 1. No smoking signs were placed on doors of all rooms where oxygen is in use or stored. Identification of Others Environmental Services Director / Designee conducted audit to identify any areas in need of no smoking signage. Systemic Changes Environmental Services Director /Designee will audit facility monthly to identify any areas where no smoking signage is needed. Monitoring Environmental Services Director will report results of audit to Safety Committee monthly for 3 months.	11/30/2012
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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring and failed to ensure damaged electrical equipment was replaced in 3 of 8 smoke compartments. The findings were: 1. Observation on 10/16/12 between 8:30 AM and	K 147	K147 It is the practice of the facility to ensure that permanent fixed wiring is in use and that damaged electrical equipment is replaced. Corrective Action 1. Electric Bed cord in room #411 was replaced. Electrical outlet faceplate in room #109 was replaced.	

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K 147	Continued From page 11 11 AM showed the electric bed cord in resident room #411 was wrapped with electrical tape. Further review showed an electrical outlet in resident room #109 had a damaged face plate. On 10/16/12 at 8:47 the environmental services director could not explain why the damaged equipment had not been noticed by the housekeeping staff during daily rounds and notify the maintenance staff. She further reported the maintenance staff did not perform routine electrical inspections. 2. Observation of the business office on 10/16/12 at 10:40 AM showed the computer was plugged into two surge protectors in-line. At the time of the observation the environmental service director reported the electrical equipment in offices were not routinely inspected. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 90-7 Examination of Equipment for Safety. ...It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations of damage ... 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 (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	2. Use of two surge protectors in-line was discontinued in the business office. Identification of Others Environmental Services Director / Designee conducted audit to identify, remove and replace any damaged electric bed cords. Environmental Services Director /Designee conducted audit to identify, remove and replace any damaged electrical outlet faceplates. Environmental Services Director /Designee conducted audit to identify, remove and replace any improperly used surge protectors in offices. Systemic Changes Environmental Services Director /Designee will audit facility monthly to identify and remove damaged electric bed cords, electrical outlet faceplates and improperly used surge protectors. The EVS Director will educate the housekeeping staff and plant ops staff to check for damaged cords and electrical outlet faceplates in resident rooms. The EVS Director will also educate office staff to the proper use of surge protectors. Monitoring Environmental Services Director will report results of audit to facility Safety Committee monthly for 3 months.	11/30/2012