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

PRINTED: 02/19/2014
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 ______	02/11/2014

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 Stories: 1 Construction type: Type V(111) Constructed: 1999 K0180: Fully Sprinkled Certified Beds: 120 Capacity: 112 Census: 98	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."	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress as required. Findings include: On 2/10/14 a padlock was securing the gate in the path of the exit discharge serving the end of the 600 corridor. On 2/10/14 a padlock was securing the gate in the path of the exit discharge serving the 400 and 500 corridor. On 2/10/14 cross corridor doors in the means of egress serving the 300 corridor and 600 corridors in the direction of the clinical need unit were secured with magnetic locks that required the use of a combination keypad to release.	K 038	This plan of correction is the facility's credible allegation of compliance. **K038** It is the practice of the facility to ensure that exit access is arranged so that exits are readily accessible at all times. **Corrective Action:** 1) Padlock securing the gate in the path of the exit discharge serving the end of the 600 corridor was removed. 2) Padlock securing the gate in the path of the exit discharge serving the end of the 400 and 500 corridors was removed. 3) The cross corridor doors in the means of egress serving the 300 corridor and 600 corridors in the direction of the clinical need unit were equipped with delayed egress devices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa J. Ralph	NHA	2/19/2014

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.

POC Accepted w/ Teresa Ralph, NHA, DD 2/20/14

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

PRINTED: 02/19/2014
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 _____	02/11/2014

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

2/20/14

(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 038	Continued From page 1 On 2/10/14 the two egress doors serving the courtyard were equipped with locking devices that require a key to operate in the direction of egress. At least one door is required to be operable without the use of a key, tool, special knowledge or effort. Locks or latches are required to be operable from the egress side of the means of egress without tools, keys, special knowledge or effort. The pad locks and magnetic locks that release via a keypad required special knowledge and effort. Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4 On 2/10/14 the door knob was mounted at 58 inches above the floor for two medications storage rooms. Locks or latches are required to be mounted between 34 and 48 inches above the finished floor. Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected 3 of 5 exit discharges and 5 of numerous doors in the means of egress.	K 038	4) The lock was removed from one door serving the courtyard. 5) The door knobs for both medication storage rooms will be mounted between 34 and 48 inches above the finished floor. **Identification of Others:** 1) Maintenance Supervisor or Designee conducted an audit of all other internal doors to ensure there are no barriers to egress from one section of the facility next. 2) Maintenance Supervisor or Designee will conduct an audit of all exterior egress doors. 3) Maintenance Supervisor or Designee will conduct an audit of all facility doors to ensure knobs are 34 to 48 inches above the floor. **Systemic Changes:** 1) Maintenance Supervisor or Designee will follow the TELS preventive maintenance system and perform quarterly safety inspections to ensure padlocks are not present on gates in the path of the exit discharge. 2) Maintenance Supervisor or Designee will follow the TELS preventive maintenance system and perform quarterly safety inspections to ensure that no internal door impedes access from	
K 046 SS=D	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.	K 046		

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

PRINTED: 02/19/2014
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 _____	02/11/2014

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

2/20/14

(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 038	Continued From page 1 On 2/10/14 the two egress doors serving the courtyard were equipped with locking devices that require a key to operate in the direction of egress. At least one door is required to be operable without the use of a key, tool, special knowledge or effort. Locks or latches are required to be operable from the egress side of the means of egress without tools, keys, special knowledge or effort. The pad locks and magnetic locks that release via a keypad required special knowledge and effort. Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4 On 2/10/14 the door knob was mounted at 58 inches above the floor for two medications storage rooms. Locks or latches are required to be mounted between 34 and 48 inches above the finished floor. Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected 3 of 5 exit discharges and 5 of numerous doors in the means of egress.	K 038	one part of the facility to the next. 3) Maintenance Supervisor or Designee will follow the TELS preventive maintenance system and perform quarterly safety inspections to ensure that no courtyard door delays egress to the facility. 4) The Maintenance Supervisor or Designee will ensure that any new or replacement door have a door knob mounted with in 34 to 48 inches above the finished floor. **Monitoring:** Maintenance Supervisor will report results of the audits to the monthly Safety Committee meeting for review and recommendation.	2/19/2014
K 046 SS=D	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.	K 046		

b

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

PRINTED: 02/19/2014
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 _____	02/11/2014

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 046	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test battery powered lights as required. Findings include: On 2/10/14 records review indicated that the required monthly 30 second test of battery powered emergency lights had not been performed since November 2013. The battery powered lights in boiler room #1 and #2 did not function when tested during the survey. The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to test battery powered lights as required increases the risk of death or injury due to fire. The deficiency affected two rooms in the facility. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3	K 046	**K046** It is the practice of the facility to ensure that hazardous areas are separated from use areas in smoke compartments. **Corrective Action:** The battery powered lights in boiler rooms number 1 and 2 were tested. Test revealed an electrical issue with the lights. An electrician has been contacted to schedule the project for repair. **Identification of Others:** This section not applicable. No other battery powered emergency lights are present in the facility. **Systemic Changes:** The Maintenance Supervisor or Designee will incorporate into the TELS preventive Maintenance system the testing of	
K 050 SS=E	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	K 050	emergency battery lights. **Monitoring:** Maintenance Supervisor will report results of the tests to the facility Safety Committee according to the TELS schedule.	2/19/2014

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

PRINTED: 02/19/2014
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	02/11/2014

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 050	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conduct fire drills as required. Findings include: On 2/10/14 records indicated that fire drills had not been conducted on the evening and night shift in the second quarter of 2013, the day and evening shift the third quarter of 2013 and the evening shift of the 4th quarter of 2013. The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to perform fire drills once per quarter per shift as required increases the risk of death or injury due to fire. The deficiency affected 5 of 12 required drills in the past year. Ref: 2000 NFPA 101 Section 19.7.1.2	K 050	**K050** It is the practice of the facility to conduct fire drills at least quarterly on each shift. **Corrective Action:** 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:** Maintenance Supervisor or 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 staff meetings at least quarterly and in new employee orientation by Maintenance Supervisor or Designee. Fire drills will be conducted each month on a rotating system, to ensure each shift has a fire drill once per quarter. **Monitoring:** Maintenance Supervisor or Designee will report results of fire drill testing annually in Safety Committee.	2/19/2014
K 067 SS=B	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 interview, the facility failed to install the air conditioning system as required.	K 067		

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

PRINTED: 02/19/2014
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 _____	02/11/2014

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 067	Continued From page 4 Findings include: On 2/10/14 the administrator confirmed that 100, 200 and 300 corridors were cooled using evaporative cooling units that provides supply air into the corridors. Resident rooms were cooled by opening resident room corridors doors and windows to the exterior to allow a flow of cooled air to the rooms. Egress corridors in healthcare occupancies are not permitted to use egress corridors as a supply system to serve adjoining areas. The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to provide an air conditioning system as permitted increases the risk of death or injury due to fire. The deficiency affected 3 of 6 corridors. Ref: 2000 NFPA 101 Section 19.5.2.1, 9.2.1; 1999 NFPA 90A Section 2-3.11.1 Refer to S&C letter 06-18 for waiver requirements for building equipped with automatic fire sprinklers.	K 067	**K067** It is the practice of the facility to maintain the heating, cooling and ventilation of the facility. **Corrective Action:** One bid from a local vendor has been secured for the project. Additional bids are being requested from not less than one additional vendor. Drawings will be submitted to the State Health Department for approval from the vendor winning the bid for the project. Upon State approval the ventilation project will begin on hall 1 of the facility. Upon completion of hall 1 project, the vendor will repair the ventilation system on hall 2 of the facility. Upon completion of the hall 2 project, the vendor will move to hall 3 to repair the ventilation system on that hall. **Identification of Others:** An audit of the ventilation duct work in the facility will be completed by the Maintenance Supervisor.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076	**Systemic Changes:** Maintenance Supervisor or Designee will check the condition of the facility ventilation system quarterly per the TELS preventive maintenance system. Any issues will be brought to the attention of the Administrator in a timely manner for resolution.	

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

PRINTED: 02/19/2014
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 _____	02/11/2014

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

2/20/14

(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 076	Continued From page 5 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store medical gasses as required. Findings include: On 2/10/14 nine oxygen concentrators were stored within the same room as seven 90 lb containers of liquid oxygen (approximately 7,000 cubic feet). Oxygen storage rooms with greater than 3,000 cubic feet of oxygen storage are not to serve any other purpose. Storage of oxygen concentrators which are a mechanical device is not permitted in the same enclosure as the liquid oxygen. The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Failure to maintain oxygen storage as required increases the risk of death or injury due to fire. The deficiency affected one of eight smoke compartments. 2000 NFPA 101 Section 19.3.2.4; 1999 NFPA 99 Section 16-3.8.1, 8-3.1.11.1, 4-3.1.1.2(a)2	K 076	**Monitoring:** Maintenance Supervisor or Designee will report the progress of the ventilation project to the Safety Committee monthly throughout the duration of the project. The Administrator will work with the Maintenance Supervisor weekly, and more often, as needed, to ensure satisfactory progress with the project. **K076** It is the practice of the facility to ensure that emergency generator tests are performed. **Corrective Action:** All Oxygen concentrators were removed from the Liquid Oxygen storage area. **Identification of Others:** The Maintenance Supervisor or Designee will conduct an audit of all oxygen storage area in the facility to ensure proper use of area. **Systemic Changes:** The Maintenance Supervisor or Designee will audit oxygen rooms per the TELS preventive maintenance schedule. **Monitoring:** The Maintenance Supervisor will bring results of the audit to the Safety Committee monthly for review.	2/19/2014 2/19/2014