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

PRINTED: 01/23/2014
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 _____	01/07/2014

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 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 with plan approval in 1967 and 1973. The building was equipped with a supervised, automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 101 residents.	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 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	**K018** It is the practice of the facility to ensure that the corridor doors close properly. **Corrective Action:** 1) The door knobs on the Sunflower Room Double Doors and Resident Room Doors #104, #114 and #512 were all adjusted to ensure doors close properly and completely. 2) All unsealed penetrations in the human resource manager's office door were repaired. **Identification of Others:** 1) Maintenance Supervisor or Designee conducted an audit of all corridor doors in the facility to ensure complete closure. 2) Maintenance Supervisor or Designee conducted an audit of all doors in the facility to ensure each is free of unsealed penetrations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa J. Ralph — TITLE: NHA — (X6) DATE: 2/18/2014

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, DN 2/19/14.

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure corridor doors would resist the passage of smoke in 4 of 8 smoke compartments. The findings were: 1. Observation on 1/7/14 between 9 AM and 12 PM showed the following corridor doors were not able to fully latch into the door frame: a. The sunflower room double doors b. Resident room #104 c. Resident room #114 d. Resident room #512 On 1/7/14 at 9:13 AM, the maintenance supervisor could not explain why the corridor doors were not noticed and repaired during the quarterly safety inspection. 2. Observation of the human resource manager's office on 1/7/14 at 10:07 AM showed corridor door had eight unsealed penetrations. The largest gap measured ¼ inch across. At the time of the observation, the maintenance supervisor could not explain why the holes had not been noticed and filled during the quarterly safety inspections.	K 018	**Systemic Changes:** 1) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure all corridor doors close completely. 2) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure all doors are free of unsealed penetrations. **Monitoring:** Maintenance Supervisor will report results of the corridor door closure audit and the audit of all doors for unsealed penetrations to the facility Safety Committee according to the TELS schedule. 2/19/2014 **K029** It is the practice of the facility to ensure that hazardous areas are separated from use areas in smoke compartments. **Corrective Action:** 1) The cardboard file boxes filled with paper have been removed from the receptionist closet. 2) The laundry room corridor doors have been adjusted to ensure proper closure with the self-closing devices. 3) The ceiling sheet rock in the boiler room has been repaired.	
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	K 029		

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K 029	Continued From page 2 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 facility staff interview, the facility failed to ensure hazardous areas were separated from use areas in 4 of 8 smoke compartments. The findings were: 1. Observation of the receptionist closet on 1/7/14 at 9:19 AM showed 8 cardboard file boxes filled with paper products were stored in the closet. Further observation showed the closet did not have a ceiling and the corridor was exposed to the combustible load of the file boxes. At the time of the observation, the maintenance supervisor was unaware of the amount of combustible retained in the closet. 2. Observation of the laundry clean linen room on 1/7/14 at 10:15 AM showed the room was equipped with two corridor doors. Further observation showed both of the doors were equipped with self-closing devices. The self-closing devices were unable to fully latch the doors into the door frames, with three attempts each. At the time of the observation, the maintenance supervisor could not explain why the doors had not been noticed and repaired during the quarterly safety inspections. 3. Observation of boiler room #1 on 1/7/14 at 10:19 AM showed a 12 inch by 14 inch section of ceiling sheetrock was missing. At the time of the observation, the maintenance supervisor reported	K 029	4) Resident Room #611 has been restored to a resident room and is no longer used for storage. **Identification of Others:** 1) Maintenance Supervisor or Designee conducted an audit of all facility supply and storage areas to ensure that combustible items are properly stored. 2) Maintenance Supervisor or Designee conducted an audit of all self-closing doors to ensure proper closure. 3) Maintenance Supervisor or Designee conducted an audit of the facility ceiling sheet rock to ensure no other damage requiring repair or replacement. 4) Maintenance Supervisor or Designee conducted an audit of the facility to ensure all storage areas have the proper self-closing door. **Systemic Changes:** 1) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure all combustible materials are properly stored. 2) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety	

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K 029	Continued From page 3 the ceiling was damaged more than one month ago with water damage. He could not explain why the hole was not repaired once the ceiling material dried out. 4. Observation of resident room #611 on 1/7/14 at 11:33 AM showed four mattress, three upholstered chairs and miscellaneous furnishings were being stored. Further observation showed the corridor door was not equipped with a self-closing device in the room. At the time of the observation, the maintenance supervisor could not explain why the self-closing device was not added when the room was converted to a storage room.	K 029	inspections to ensure all self-closing doors close properly. 3) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure all ceiling area damage is repaired in a timely manner. 4) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure all storage areas have the proper self-closing device.	
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 facility staff interview, the facility failed to ensure 2 of 8 exit discharge pathways were unobstructed and failed to ensure 2 of 2 access control doors were equipped with all safety devices. The findings were: 1. Observation on 1/7/14 between 9 AM and 9:30 AM showed the exit discharge pathways from the sunflower room and hall 4 were obstructed with drifted snow. The largest snow drift was 3 feet tall and 15 feet long. On 1/7/14 at 9:09 AM, the maintenance supervisor reported the snow had	K 038	**Monitoring:** Maintenance Supervisor will report results of the storage audits, door closure audit and the ceiling damage audit to the facility Safety Committee according to the TELS schedule. **K038** It is the practice of the facility to ensure that all exit discharge pathways are unobstructed and that access control doors are equipped with all safety devices. **Corrective Action:** 1) Snow drift across the walk from the Sunflower Room side exit and the snow drift across the walk from the hall 4 side exit were cleared.	2/19/2014

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K 038	Continued From page 4 drifted from strong winds over the past two days. He could not explain why the drifts had not been removed at least daily and after the storm abated the previous day. 2. Observation on 1/7/14 between 10:30 AM and 11 AM showed the two sets of double doors leading into the special care unit were access control doors. Further observation showed the doors were not equipped with a release push button or a motion sensor. On 1/7/14 at 10:58, the maintenance supervisor reported he was unaware access control doors required the aforementioned safety devices. NFPA 101, 2000 Edition, 19.2.1; 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038	2) The two sets of double doors leading into the special care unit will be converted to delayed egress access. **Identification of Others:** 1) Maintenance Supervisor or Designee conducted an audit of all facility exits to ensure nothing was blocking access to the means of egress. 2) Maintenance Supervisor or Designee conducted an audit of all other internal doors on 2/3/2014 to ensure there are no barriers to egress from one section of the facility next. **Systemic Changes:** 1) Maintenance Supervisor or Designee will audit all facility exits 2x per day, or more often depending on weather conditions, to ensure there is no snow or other debris blocking the egress. 2) Maintenance Supervisor or Designee will follow the TELS preventive maintenance program and perform quarterly safety inspections to ensure that no internal door impedes access from one part of the facility to the next.	
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 facility staff interview, the facility failed to ensure fire drills			

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K 038	Continued From page 4 drifted from strong winds over the past two days. He could not explain why the drifts had not been removed at least daily and after the storm abated the previous day. 2. Observation on 1/7/14 between 10:30 AM and 11 AM showed the two sets of double doors leading into the special care unit were access control doors. Further observation showed the doors were not equipped with a release push button or a motion sensor. On 1/7/14 at 10:58, the maintenance supervisor reported he was unaware access control doors required the aforementioned safety devices. NFPA 101, 2000 Edition, 19.2.1; 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038	**Monitoring:** Maintenance Supervisor will report results of the egress audit to the facility Safety Committee in accordance with the TELS schedule.	2/19/2014
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 facility staff interview, the facility failed to ensure fire drills	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.	

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K 050	Continued From page 5 were held on 3 of 3 shifts on a quarterly basis. 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 showed a fire drill was not conducted on the first shift during the first and third quarters of 2013. A fire drill was not conducted on the second shift during the second and third quarters of 2013. A fire drill was not conducted on the third shift during the second quarter of 2013. On 1/7/14 at 4:45 PM, the maintenance supervisor could not explain why the previous maintenance supervisor had not conducted the aforementioned fire drills.	K 050	**Monitoring:** Maintenance Supervisor or Designee will conduct a fire drill on each shift each month for 3 months to ensure education of staff and compliance. Maintenance Supervisor or Designee will report results and trends of fire drills in Safety Committee meetings each month.	2/19/2014
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, observation and facility staff interview, the facility failed to ensure the fire alarm system was tested on an annual basis and	K 052	**K052** It is the practice of the facility to conduct fire alarm system testing annually. **Corrective Action:** An annual fire alarm system test was administered on 1/20/2014 by Rapid Fire Protection, Inc. Test results found the system to be in good standing. **Identification of Others:** N/A **Systemic Changes:** Maintenance Supervisor will oversee the annual fire alarm system test according to TELS schedule. **Monitoring:** Maintenance Supervisor or Designee will report results of fire alarm testing annually in Safety Committee.	

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K 052	Continued From page 6 failed to ensure the central station certificate was posted. The findings were: 1. Review of the fire alarm system testing records showed the last annual inspection occurred on 12/6/11, more than 12 months ago. On 1/7/14 at 4:45 PM, the maintenance supervisor could not explain why the system had not been tested in the past year. 2. Observation of the fire alarm control panel on 1/7/14 at 1:31 PM showed the central station certificate was not posted. At the time of the observation, the maintenance supervisor reported he was unaware the certificate was required to be posted within 36 inched of the fire alarm control panel. NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 5-2.2.3.1.1 Fire alarm systems providing services that complies with all the requirements of this code shall be certified by the organization that has listed the central station, and a document attesting to this certification shall be located on or within 36 in. of the fire alarm system control unit or, if no control unit exists, on or within 36 in. of a fire alarm system component. 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 14. Remote Annunciator, ... annually 15. Initiating Devices	K 052		

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K 052	Continued From page 7 a. Duct Detectors, ... annually b. Electromechanical Releasing Device (Smoke Dampers), ...annually e. Heat Detectors, ... annually f. Fire Alarm Boxes, ... annually h. All Smoke Detectors, ... annually i. Smoke Detectors-Sensitivity, ... bi-annually a. Audible Devices, ... annually c. Visible Devices, ... annually	K 052	**K062** It is the practice of the facility to ensure that the sprinkler system pressure gauges and the antifreeze sprinkler system are maintained. **Corrective Action:** 1) The missing sprinkler system pressure gauge was replaced on 1/20/2014 by Rapid Fire Protection, Inc. 2) The antifreeze in the sprinkler system was changed to a 50/50 solution on ~~1/20/2014~~ to address lower temperatures during the winter months. 2/19/14 **Identification of Others:** 1) N/A 2) N/A **Systemic Changes:** 1) Maintenance Supervisor or Designee will follow the TELS preventive maintenance schedule to audit the Sprinkler system pressure gauges to ensure they are operating and in good repair. 2) Maintenance Supervisor or Designee will follow the TELS preventive maintenance schedule to audit the antifreeze used in the sprinkler system to ensure it is adequate for the weather conditions.	
K 062 SS=F	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, 9.7.6 This STANDARD is not met as evidenced by: Based on observation, record review and facility staff interview, the facility failed to ensure sprinkler system pressure gauges were maintained and failed to ensure the antifreeze sprinkler system was maintained. The findings were: 1. Review of the sprinkler system testing record dated 3/19/13 showed the contractor indicated pressure gauge on the system side of the back flow preventer was missing. The three subsequent quarterly inspection reports had the same comment. Observation of the sprinkler riser on 1/7/14 at 4:55 PM, confirmed the gauge was missing. At the time of the observation, the maintenance supervisor reported he had asked the sprinkler contractor to replace the gauge, but	K 062		

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K 062	Continued From page 8 had not yet scheduled an installation time. 2. Review of the anti-freeze sprinkler system testing records showed the glycol anti-freeze solution was rated at +3 degrees on 9/26/13. On 1/7/14 at 4:45 PM, the maintenance supervisor confirmed the low temperature at the facility had already reached -20 degrees this year. He could not explain why the sprinkler contactor had not modified the anti-freeze solution to meet the expected atmospheric conditions. NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA 13, 1999 Edition; 4-1.1 Pressure Gauges. A listed pressure gauge conforming to 5-15.3.2 shall be installed in each system riser. Pressure gauges shall be installed above and below each alarm check valve where such devices are present. 4-5.2.3 An anti-freeze solution shall be prepared with a freezing point below the expected minimum temperature for the locality ...	K 062	**Monitoring:** Maintenance Supervisor or Designee will report results of audits to the Safety Committee according to the TELS schedule. Necessary action will be taken by the committee as needed to ensure compliance.	2/19/2014
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 facility staff interview, the facility failed to ensure the ventilation system was maintained in 3 of 5 wings. The findings were:	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.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 _____	01/07/2014

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

2/19/14

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K 067	Continued From page 9 Observation of the ventilation system on 1/7/14 at 3:42 PM showed the duct work in hall 1, 2 and 3 had been crushed flat. At the time of the observation, the maintenance supervisor reported the ventilation blower and motor were not operable. He also reported the ventilation system in hall 4 was replaced in 2012. He could not explain why the system was not replaced throughout the facility when the hall 4 system was installed.	K 067	**Identification of Others:** An audit of the ventilation duct work in the facility was completed on 2/3/2014 by the Maintenance Supervisor. **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. **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.	2/18/2014
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and facility staff interview, the facility failed to ensure 1 of 5 emergency generator tests was performed. The findings were: Observation of the emergency generators on 1/7/14 at 10:21 AM showed sealed lead acid batteries were in use. Review of the emergency generator testing log showed the facility was not performing conductance tests on sealed lead acid batteries. On 1/7/14 at 4:45 PM, the maintenance supervisor reported he was unaware of the	K 144	**K144** It is the practice of the facility to ensure that emergency generator tests are performed. **Corrective Action:** A Conductance Test was preformed per requirement. **Identification of Others:** N/A	

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	535024	A. BUILDING 01 ✓MAIN BUILDING 01 B. WING _____	01/07/2014

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

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K 144	Continued From page 10 conductance test requirement. Reference NFPA 101, 2000 Edition, 19.6.1, 9.1.3, NFPA 110, 1999 Edition; 6.3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 110, 2005 Edition 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specifics gravity when applicable and warranted.	K 144	**Systemic Changes:** Monthly testing of the Lead-acid generator battery will be conducted per TELS. **Monitoring:** Results of the Lead-acid generator battery testing will be brought to the Safety Committee monthly for review.	2/19/2014
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 facility staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 8 smoke compartments. The findings were: Observation of the resident room #108 on 1/7/14 at 9:49 AM showed the lights for a Christmas tree were plugged into a 6-way power tap. At the time of the observation, the maintenance supervisor reported he was unaware there was a difference between multi-plug adapters and surge protectors. He also reported the quarterly safety inspections did not ensure multi-plug adapters	K 147	**K147** It is the practice of the facility to ensure the use of proper electrical wiring and equipment. **Corrective Action:** Identified power strip was replaced with a surge protector. **Identification of Others:** Maintenance Supervisor or Designee conducted an audit of all rooms in the facility to locate any other use of power cords. **Systemic Changes:** All power strips will be removed from the facility and replaced with surge protectors. Maintenance Supervisor or Designee will audit the facility per the TELS schedule to ensure proper use of surge protectors. **Monitoring:** Maintenance Supervisor or Designee will report results of the audit to the Safety Committee monthly.	2/19/2014

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 11 were surge protectors. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 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 (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and facility staff interview, the facility failed to ensure alcohol based hand	K 211	**K211** It is the practice of the facility to ensure the proper use of Alcohol Based Hand Rub dispensers. **Corrective Action:** Alcohol Based Hand Rub dispenser was removed from area near microwave. **Identification of Others:** Maintenance Supervisor or Designee conducted audit of facility to identify location of all Alcohol Based Hand Rub dispensers. **Systemic Changes:** Maintenance Supervisor or Designee will ensure that all Alcohol Based Hand Rub dispensers correctly located in the facility by conducting ongoing audits per the TELS schedule. **Monitoring:** Maintenance Supervisor or Designee will bring the results of the dispenser audit to the monthly Safety Meeting per TELS schedule.	2/19/2014

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K 211	Continued From page 12 rub (ABHR) dispensers were not installed over ignition sources in 1 of 8 smoke compartments. The findings were: Observation of the sunflower dining room on 1/7/14 at 9:07 AM showed an ABHR dispenser was installed above a microwave oven. At the time of the observation, the maintenance supervisor could not explain why the microwave oven was placed under the ABHR dispenser.	K 211		