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WY Dept of Health
MAR 25 2016

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

PRINTED: 03/24/2016
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 _____	R 03/21/2016

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 96 residents.	{K 000}		3/28/16
{K 018} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by:	{K 018}	**K-018 NFPA 101 Life Safety Code Standard** **Corrective Action:** A pass through door that is in compliance with NFPA 101 19.3.6.2 has been installed. **Identification of Others:** There are no other pass through doors requiring attention. **Systemic Actions:** A door will be provided in the dining room pass through that will prevent the passage of smoke per NFPA 101 19.3.6.3.2. The Maintenance Director or designee will check the doors for compliance on a monthly basis.	

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

Admin — 3/25/16

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 via phone call with Administrator Tony Janusz on. 03/25/16 at 10:25AM.

34354

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{K 018}	Continued From page 1 Based on observation and staff interview, the facility failed to provide doors that resisted the passage of smoke in 1 of 8 smoke compartments. The findings were: Observation on 03/21/16 at 1:15 PM revealed a pass through opening between the kitchen and the dining room area, that was open to the corridor. Further observation revealed the pass through opening was equipped with doors, but was not provided with a means suitable for keeping the doors closed. At the time of the observation the Facility Maintenance Manager acknowledged the pass through window doors would not latch. Ref: 2000 NFPA 101, Section 19.3.6.3.2	{K 018}	**Monitoring:** The QAPI Committee will evaluate effectiveness of the plan based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	
{K 046} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation identifying a maintenance policy of the battery-operated emergency lighting for 1 of 1 emergency lights. The findings were: Document review of the testing and maintenance documentation on 03/21/16 from 1:50 PM to 2:15 PM revealed no documentation was available to indicate that the required 30 second monthly and 90 minute annual testing of the battery operated light, located at the automatic transfer switch, had been preformed. Interview with the Facility Maintenance Manager at the time of the review	{K 046}	K-046: NFPA 101 Life Safety Code Standard **Corrective Action** The testing of the battery operated light located at the automatic transfer switch has been completed. **Identification of Others:** The Maintenance Director has done a facility sweep for any battery operated lighting for documentation of testing. Those not compliant will be tested. **Systemic Changes:** The Maintenance Director and/or	3/28/16

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{K 046}	Continued From page 2 indicated that the testing had been completed, but no documentation was available. Ref: 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3	{K 046}	designee will document the annual 30 sec and 90 minute testing on battery operated emergency lighting in the facility. **Monitoring:** The QAPI Committee will evaluate effectiveness of the plan based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	
{K 052} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review, and staff interview, the facility failed to ensure that the fire alarm system was tested and maintained per the requirements of NFPA 72. The findings were: Document review on 03/21/16 from 1:50 PM to 2:15 PM of the testing and maintenance records for the fire alarm system revealed the last semi-annual battery load voltage test was completed in May 2015. At the time of the document review the Facility Maintenance Manager acknowledged the testing requirement and the missing documentation, but stated that the outside contractor performing the testing had not returned to the facility to complete the required test. Ref: 2000 NFPA 101, Sections 19.3.4.1 and 9.6.1.4 1999 NFPA 72, Table 7-3.2 (6)(d)(3)	{K 052}	**K-052: NFPA 101 Life Safety Code Standard** **Corrective Action:** The Maintenance Director has ensured the Annual Fire Alarm system has been put in compliance with NFPA 70 and 72 and the UL Certificate has been posted on the Central Station Alarm system with the current expiration date. **Identification of Others:** No other areas have been affected by this. **Systemic Changes:** The Maintenance Director and/or designee will develop a tickler file to trigger an annual UL Certification per NPFA 70 and 72.	3/28/16
{K 144} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	{K 144}		

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{K 144}	Continued From page 3 Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure maintenance and testing of the generator were being performed per the requirements of NFPA 110 for 1 of 1 generators. The findings were: Document review of the generator maintenance and testing records on 03/21/16 from 1:50 PM to 2:15 PM revealed there was no documentation available for review at the time of the survey. Interview with the Facility Maintenance Manager at the time of the review confirmed that weekly inspections and monthly load test were not being performed. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.3 1999 NFPA 110, Section 6-4.1	{K 144}	**Monitoring:** The QAPI Committee will evaluate effectiveness of the plan to ensure compliance then reassess the need for continued monitoring based on compliance until resolved. **K-144: NFPA 101 Life Safety Code Standard.** **Corrective Actions:** The Maintenance Director has conducted an inspection and a load test for 30 minutes in accordance with NFPA 99 and 110. **Identification of Others:** There were no other areas affected. **Systemic Changes:** The Maintenance Director and/or designee will conduct weekly inspection and exercise under load for 30 minute monthly tests per NFPA 99 and 110. The Maintenance Director will document these results. **Monitoring:** The QAPI Committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	3/28/16

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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
535024 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/21/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	02/23/2016	LSC K0047	02/23/2016	LSC K0050	02/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	02/23/2016	LSC K0064	02/23/2016	LSC K0069	02/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0070	02/23/2016	LSC K0076	02/23/2016	LSC K0106 WAIVER	02/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0143	02/23/2016	LSC K0147	02/23/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	3/25/16		34354	3/21/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO