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

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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	07/29/2016

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 Nursing Homes 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, one-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 branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 102.	K 000	**K-029: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** The area located in the supplies room and in the boiler room in the 600 hall have had the penetrations filled with fire caulking. Items located in the bathroom in the SCU have been removed and the area cleaned .A self closing device has been installed on the door to the bathroom in the SCU. **Identification of Others:** The Maintenance Director or designee has inspected the facilities smoke compartments for compliance with NFPA Life Safety Code Standards. Non-compliant areas in the Smoke Compartments have been remedied. **Systemic Changes:** The Administrator has educated the Maintenance Staff on NFPA 101 regulations regarding smoke compartments. The Maintenance Director or designee will inspect the smoke compartments during his weekly facility rounds for compliance with NFPA Life Safety Code Standards. The Administrator or designee will do random facility rounds weekly for compliance. Non-compliant areas will be remedied timely. **Monitoring:** The Maintenance Director or designee	8/29/16
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 provide rated construction for a hazardous area in accordance with NFPA 101 in 2 of 8 Smoke compartments. The findings were: 1. Observation on 07/28/2016 at 8:55 AM located in the supplies room of the SCU area and at 10:00 AM in the Boiler room adjacent to the 600	K 029		

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

Admin 8/21/16

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.

Accepted POC onsite with Administrator Tony Janusz 9/1/2016. signing for Pat Davis

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K 029	Continued From page 1 corridor revealed there were pipe penetrations for routing of wiring. The annular space between the pipe and the wiring was not filled with fire caulking. Interview with the Facility Maintenance Manager at the time of observation acknowledged the observation. 2. Observation on 07/28/2016 at 9:31 AM located in the employee bathroom of the SCU area revealed that the area was being utilized as a storage room with combustible materials. The shower stall was filled full of clothing and boxes that protruded into and in front of the toilet. Further observation revealed that the toilet room was not provided with a closing device on the door. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the area was being used as storage and that the area was missing a closing device on the door. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	will present their weekly reports to the monthly Safety Committee for review and recommendations if necessary. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-038: NFPA LIFE SAFETY CODE STANDARD** **Corrective Actions:** Proper signage indicating the use of delayed egress door locking systems have been placed on the egress doors from the 500 hall to the 600 hallway. The Exit sign was removed from the east facing gate. Hand rails have been installed along the west facing ramp adjacent to the 400 hallway. The bed sheet on the SCU north exit door was removed at the time of the observation. **Identification of Others:** The Maintenance Director or designee has inspected the facility exit accessibility and proper signage. Doors not in compliance were remedied. **Systemic Changes:** The Administrator has educated the Maintenance staff on the NFPA 101 Life Safety Code Standards regarding proper signage and accessibility of Exit doors and delayed egress doors.	8/28/16
K 038 SS=D	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 staff interview, the facility failed to provide exits that are readily accessible at all times in accordance with NFPA 101 in 1 of 8 smoke compartments. The findings were: 1. Observation on 7/28/2016 at 9:37 AM located at the SCU doors from the 500 corridor to the 600 corridor revealed delayed egress doors without	K 038		

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K 038	Continued From page 2 proper signage indicating the use of a delayed egress door locking system. Interview with the Facility Maintenance Manager at the time of observation was unaware of this requirement. Ref: 2000 NFPA 101, Sections 19.2.1, 19.2.2.2.4, and 7.2.1.6.1 2. Observation on 07/28/2016 at 8:44 AM located in the courtyard adjacent the 500 corridor revealed a marked exit on a east facing gate that when opened revealed no sidewalk to the public way. Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirements. 3. Observation on 07/28/2016 at 8:44 AM located in the courtyard adjacent to the 100 corridor revealed a west facing ramp to the public way that was greater than 6 inches of rise without hand rails. Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirements. 4. Observation on 07/28/2016 at 8:40 AM located at the SCU North Exit Doors adjacent to 500 Corridor revealed a bed sheet tied around the panic hardware in a knot restricting any travel to or from the exit doors. At the time of observation the Facility Maintenance Manager asked other employees why there was a bed sheet tied around the exit doors. Employees indicated to the Facility Maintenance Manager that there was a lock down the night before due to a shooting nearby and they had forgotten to remove the bed sheet. The Facility Maintenance Manager was able to remove the bed sheet within 5 minutes of the observation.	K 038	The Maintenance Director or designee will inspect the facility exits and delayed egress doors for compliance during his weekly facility rounds. The Administrator will randomly round to ensure compliance. **Monitoring:** The Maintenance Director or designee will present their weekly reports to the monthly Safety Committee for review and recommendations if necessary. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-050: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** The Maintenance Director and staff have been educated on the requirement for facility fire drills per facility policy and NFPA 101 Life Safety Code Standards. **Identification of Others:** The Maintenance Director did an audit of fire drills back to 1/11/16. Missed drills cannot be made up. **Systemic Changes:** The Maintenance Staff was educated on fire drill policy and NFPA requirements by the Administrator. The Maintenance Director or designee	8/28/16

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K 038	Continued From page 3 Ref: 2000 NFPA 101, Sections 19.2.1 and Chapter 7	K 038	will perform fire drills per policy and NFPA requirements and document the drills in the facilities TELS system. **Monitoring:**	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide fire drills held at unexpected times and at least quarterly on each shift in 4 of 4 quarters. The findings were: Document review on 07/28/2016 at 11:35 AM revealed only two fire drills, recorded in the months of February 2016 and May 2016, for the past year. Document review of the two prior surveys revealed the facility was cited on 04/29/2015, and 01/11/2016 for the same deficiency. Interview with the Facility Maintenance Manager verified that fire drills had not been conducted. Ref: 2000 NFPA 101, Section 19.7.1.2	K 050	The Maintenance Director or designee will present their fire drill reports to the monthly Safety Committee for review and recommendations if necessary. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-052: NFPA 101 LIFE SAFETY CODE STANDARD.** **Corrective Actions:** The Maintenance Director has obtained an updated UL Certification. The documentation of the battery load voltage test was located and placed in the Life Safety Binder. Documentation of the Maintenance and testing of the fire alarm system has been located and placed in the Life Safety Binder. **Identification of Others:** There were no other areas of Life Safety affected by this. **Systemic Changes:** The Maintenance Staff has been educated on the importance of documentation regarding NFPA 101 Life Safety Code Standards and	8/28/16 TO
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052	Continued From page 4 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, observation, 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: 1. Observation and document review on 07/28/2016 at 10:48 AM revealed the central station fire alarm system UL certificate was posted at the annunciator panel, but expired March 2016. Document review of prior surveys revealed the facility was cited on 01/11/2016 for the same deficiency. Interview with the Facility Maintenance Manager at the time of the review acknowledged the certificate was expired, and was unaware there was an expiration date. Ref: 2000 NFPA 101, Sections 19.3.4.1 and 9.6.1.4 1999 NFPA 72, Section 1-6.2.3.1.1 2. Document review on 07/28/2016 at 11:30 AM 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. Document review of prior surveys revealed the facility was cited on 01/11/2016 for the same deficiency. At the time of the document review the Facility Maintenance Manager acknowledged the missing documentation.	K 052	maintaining an organized binder to make the information readily available. The Maintenance Staff has been educated on the facility policy on certifications, checks, testing and maintenance to comply with NFPA 101 Life Safety Code Standards. The Maintenance Director or designee will perform the required tests, certifications, maintenance and checks per facility Life Safety Policy and as required by NFPA 101 Life Safety Code Standards. **Monitoring:** The Maintenance Director or designee will present a weekly report to the Administrator indicating the Life Safety tasks required are completed. Non-compliance will be remedied The Maintenance Director or designee will present their reports to the monthly Safety Committee for review and recommendations if necessary. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-062: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Actions.** The Maintenance Director has contacted Western States for the proper documentation and posting of the Hydraulic Calculations on the facility	8/28/16

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K 052	Continued From page 5 3. Document review on 07/28/2016 at 11:32 AM of the testing and maintenance of the fire alarm system revealed that the documentation was not available to demonstrate the following tests: a) Monthly Activation - NFPA 72, table 7-3.2, 23 b) Annual - Annunciator Panel(s) - NFPA 72, Table 7-3.2, 14 c) Annual - Sealed Lead Acid Battery Inspection - NFPA 72, Table 7-32, 6 d) Annual - Alarm Notification Appliances - NFPA 72, Table 7-3.2, 19 e) Annual - Manual Fire Alarm Boxes - NFPA 72, Table 7-3.2, 15 f) Annual - Heat Detectors - NFPA 72, Table 7 -3.2, 15 g) Annual - Smoke Damper Operation - NFPA 90A, 4-4.1 h) Annual - Smoke Detector (in place, smoke entry) - NFPA 72, Table 7-3.2, 15 i) Bi-annual - Smoke Detector sensitivity, NFPA 72, Table 7-3.2, 15 j) Quarterly - Water flow Alarm Devices (less than 90 sec.) - NFPA 25, 9-2.7 and NFPA 72, 2-6.2 k) Quarterly - Supervisory Signal Devices (valves, hi/low air) - NFPA 72, Table 7-3.2, 15 Interview with the Facility Maintenance Manager at the time of review confirmed there were no documents available for review. Ref: 2000 NFPA 101, Sections 19.3.4.1 and 9.6.1.4	K 052	fire riser. The documentation for the testing and maintenance of the Automatic Sprinkler System was located and placed in the facility Life Safety binder. The masking tape on the sprinkler heads in room 606 was removed at the time of discovery. **Identification of Others:** The Maintenance Director did a room to room inspection of the facility's sprinkler heads for obstructions. Non-compliant sprinkler heads were remedied timely. **Systemic Changes:** The Maintenance Staff has been educated on the importance of documentation regarding NFPA 101 Life Safety Code Standards and maintaining an organized binder to make the information readily available. The Maintenance Staff has been educated on the facility policy on certifications, checks, testing and maintenance to comply with NFPA 101 Life Safety Code Standards. The Maintenance Director or designee will perform the required tests, certifications, maintenance and checks per facility Life Safety Policy and as required by NFPA 101 Life Safety	
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	K 062	Code Standards to include the Hydraulic Calculations postings on the facility fire riser The Maintenance Director or designee will inspect the automatic sprinkler heads weekly during his facility rounds. The	

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K 062	Continued From page 6 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 that the automatic sprinkler systems are installed, and continuously maintained per the requirements of NFPA 13 and 25 in 2 of 8 smoke compartments. The findings were: 1. Observation of the sprinkler riser room on 07/28/2016 at 10:29 AM revealed the fire riser had been modified from the original installation for the addition of a reduce pressure principle backflow preventer and valves. No hydraulic calculations were posted. Document review of prior surveys revealed the facility was cited on 01/11/2016 for the same deficiency. Interview with the Facility Maintenance Manager at the time of observation was unaware the hydraulic calculations were missing. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Sections 5-515.4.6.2 and 10-5 2. Document review of the testing and maintenance of the automatic sprinkler system on 07/28/2016 at 11:30 AM revealed that documentation was not available to demonstrate the main drain had been tested in the past 12 months. Document review of prior surveys revealed the facility was cited on 01/11/2016 for the same deficiency. Interview with the Facility Maintenance Manager at the time of the review confirmed no documentation was available. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1	K 062	Administrator will do random inspections weekly to ensure compliance. Non-compliance will be remedied timely. **Monitoring:** The Maintenance Director or designee will present a weekly report to the Administrator indicating the Life Safety tasks required are completed. Non-compliance will be remedied The Maintenance Director or designee will present their reports to the monthly Safety Committee for review and recommendations if necessary. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **F-064: NFPA 101 LIFE SAFETY CODE STANDARD.** **Corrective Actions:** The facility fire extinguishers were reinstalled to meet NFPA 10. **Identification of others:** There are no other areas affected by this. **Systemic Changes:** The Maintenance Staff were educated on the fire extinguisher height requirements by the Administrator. The Maintenance Director or designee will ensure any new installation of fire	8/12/16

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K 062	Continued From page 7 1999 NFPA 25, Sections 9-2.6 3. Observation on 07/28/2016 at 9:55 AM located in room 606 revealed that the sprinklers in two closets were both obstructed and covered with masking tape. At the time of the observation the Facility Maintenance Manager acknowledged the obstructed sprinkler heads and removed the tape. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.5 1998 NFPA 25, Section 2-2.1.1	K 062	extinguishers will meet NFPA 10 code for height requirements. **Monitoring:** The Maintenance Director or designee will report to the Safety Committee any new installations of fire extinguishers and show proof of compliance with NFPA 10. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved.	
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10. The finding were: Observation on 07/28/2016 at 8:56 AM in the SCU supplies closet, at 10:13 AM in the 200 corridor adjacent to room 211, at 10:22 AM in the 100 Corridor adjacent to room 114, and throughout the facility revealed fire extinguishers installed with the top of the extinguisher ranging from 65-70 inches from the ground. Interview with the Facility Maintenance Manager at the time of observation was unaware of the height requirement. Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1998 NFPA 10, Section 1-6.10	K 064	**K-066: NFPA 101 LIFE SAFETY CODE STANDARD** Corrective Actions: The Maintenance Director has supplied the smoking area adjacent to the janitor's office of the SCU with a noncombustible ashtray. **Identification of Others:** The Maintenance Director or designee inspected the facility smoking areas for compliance with NFPA 101 regarding noncombustible ashtrays. Non-compliant areas were remedied timely. **Systemic Changes:** The Maintenance Staff were educated on the NFPA 101 regarding noncombustible ashtrays in smoking areas.The Maintenance Director or designee will inspect the smoking areas of the facility weekly during his	8/28/16

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K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to meet the smoking area requirements in accordance with NFPA 101. The findings were: Observation on 07/28/2016 at 9:22 AM located outside and adjacent to the janitor's office of the SCU revealed a smoking area that did not provide noncombustible ashtrays. Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirement. Ref: 2000 NFPA 101, Section 19.7.4	K 066	facility rounds for compliance. The Administrator will do random rounds weekly to ensure compliance. Non-compliance will be remedied timely. **Monitoring:** The Maintenance Director or designee will report to the Safety Committee any non-compliance. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-144: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** The required monthly and weekly tests on the generator have been completed and up to date. **Identification of Others:** There are no other areas that are affected by this. **Systemic Changes:** The Maintenance Staff has been educated on the facility policy on certifications, checks, testing and maintenance to comply with NFPA 101 Life Safety Code Standards to include generator tests and inspections. The Maintenance Director or designee will perform the required tests, certifications, maintenance and checks	8/28/16
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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	535024	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/29/2016

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 144 SS=D	Continued From page 9 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 that the generator maintenance and testing were being performed per the requirements of NFPA 110 for 1 of 1 generators. The findings were: Document review on 07/28/2016 at 11:30 AM revealed missing monthly generator tests for the month of June. Further observation revealed the test in July was only done for a time frame of 20 minutes and there was no indication of weekly inspections. Interview with the Facility Maintenance Manager at the time of the review confirmed that weekly inspections had not been documented and then for the month of June confirmed there was no generator test. The Maintenance Manager also confirmed that he was unaware of the 30 minute requirement for the monthly load test. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.3 1999 NFPA 110, Section 6-4.1	K 144	per facility Life Safety Policy and as required by NFPA 101 Life Safety Code Standards to include weekly and monthly generator tests and inspections. **Monitoring:** The Maintenance Director will give a report regarding the generator inspection and tests to the Administrator weekly for review. Non-compliance will be remedied timely. The Maintenance Director or designee will report to the Safety Committee any non-compliance. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved. **K-147: NFPA 101 LIFE SAFETY CODE STANDARD.** **Corrective Actions:** The outlets noted in the SCU bathroom and in Social Services have had GFC outlets installed.	8/20/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical wiring and	K 147	**Identification of Others:** The Maintenance Director has inspected the facility sinks for electrical receptacle within 60 inches that are not ground fault circuit interrupters. Non-compliant receptacles have been remedied.	

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

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K 147	Continued From page 10 equipment in accordance with NFPA 70 in 2 of 8 smoke compartments. The findings were: Observation on 07/28/2016 at 9:31 AM located in the SCU employee bathroom (1 receptacle) and in the social service room (2 receptacles) revealed electrical receptacles next to a sinks closer than 60" without ground-fault circuit-interruption. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupters. Ref: 1999 NFPA 70, Article 210.8	K 147	**Systemic Changes:** The Maintenance Director or designee will inspect any new electrical receptacles being installed in areas where a sink exists for compliance. Non-compliance will be remedied timely. **Monitoring:** The Maintenance Director or designee will report to the Safety Committee any non-compliance. The Safety Committee will present the recommendations and reports to the monthly QAPI for review and effectiveness. Corrective actions will be taken where necessary until resolved.	