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

PRINTED: 09/14/2016
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 09/01/2016

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	{K 000}	K-029: NFPA 101 LIFE SAFETY CODE STANDARD	9/9/16
{K 029} SS=D	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 (000) construction built in 1961. The building was equipped with a supervised automatic wet and anti-freeze sprinkler system with an addressable fire alarm system. The facility had a capacity of 105 certified Medicare and Medicaid beds with a census of 98. 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 1 of 8 Smoke compartments. The findings were: Observation on 09/01/2016 at 1:20 PM 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	{K 029}	**Corrective Action:** 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. A shower head has been installed in the shower. **Identification of Others:** There are no other areas affected by this. **Systemic Changes:** The Maintenance Director or designee has installed a sign on the front of the door to the SCU bathroom indicating that it is not to be used as storage. The Maintenance Director or Designee will round weekly to ensure the room is not used for storage and the sprinkler head is in place and the self closing device is in working order. **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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: admin — (X6) DATE: 9/16/16

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.

RECEIVED
WY Dept of Health
SEP 16 2016
Healthcare Licensing and Surveys

POC approved by Lynda Peta 9/30/16
Spoke to Tony
Reviewed and approved 9/30/16

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{K 029}	Continued From page 1	{K 029}	K-038: NFPA LIFE SAFETY CODE STANDARD	9/21/16
{K 038} SS=D	stall contained bags of clothing, a closet hanger rod, and other material. Further observation revealed that shower stall did not have a sprinkler head and the toilet room was not provided with a closing device on the door. Document review of prior surveys revealed the facility was cited on 07/28/2016 for the same deficiency. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the area was being used as storage. Ref: 2000 NFPA 101, Section 19.3.2.1 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. The findings were: Observation on 09/01/2016 at 1:25 PM 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. Document review of prior surveys revealed the facility was cited on 07/28/2016 for the same deficiency. Interview with the Facility Maintenance Manager at the time of observation stated that a contractor was delayed on installing the hand rails. Ref: 2000 NFPA 101, Sections 19.2.1 and Chapter 7 NFPA 101 LIFE SAFETY CODE STANDARD	{K 038}	**Corrective Actions:** Hand rails have been installed along the west facing ramp adjacent to the 400 hallway. **Identification of Others:** There are no other areas affected by this. **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. 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 062}		{K 062}		

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{K 062} SS=D	Continued From page 2 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the automatic sprinkler systems are installed, and continuously maintained per the requirements of NFPA 13 and 25 in 1 of 8 smoke compartments. The findings were: Observation of the sprinkler riser room on 09/01/2016 at 1:30 PM 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, and 07/28/2016 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 9.7.5 1998 NFPA 25, Section 2-2.1.1	{K 062}	K-062: NFPA 101 LIFE SAFETY CODE STANDARD **Corrective Actions.** Documentation from Western States Fire has been obtained stating that they were not the company who did the modifications and no record of who had is not available. **Identification of Others:** There are no other areas affected by this. **Systemic Changes:** The Maintenance Director or Designee will ensure that any modifications made to the sprinkler riser will have calculations provided. **Monitoring:** New modifications and calculations will be presented to the Safety Committee for approval and then presented to the QAPI committee for submission.	9/9/16

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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	9/1/2016 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	K0050	08/28/2016	LSC	K0052	08/28/2016	LSC	K0064	08/28/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0066	08/28/2016	LSC	K0144	08/28/2016	LSC	K0147	08/28/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			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
				09/09/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/29/2016	