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

PRINTED: 08/31/2017
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
	565024	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/16/2017

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 A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 8/16/2017. 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 2012 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 79 residents.	K 000		
K 211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7 and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 8/16/2017 at 10:19 AM at the Secured Care Unit east exit revealed tree branches blocking access to the sidewalk and	K 211	K211 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1a. On 08/17/2017 the trees were trimmed and no longer block access to the sidewalk and exit gate. 1b. On 09/05/2017 the kitchen and kitchen storage area door knobs were replaced,	8/17/17 9/5/17

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

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.

Administrator 9/10/17

SEP 18 2017
Healthcare Licensing and Surveys

POC ACCEPTED VIA PHONE CALL ~~&~~ WITH ADMINISTRATOR BRUCE ODENTHAL ON 9-19-17

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

PRINTED: 08/31/2017
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	08/16/2017

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 211	Continued From page 1 exit gate. The means of egress must be continuously maintained free of obstructions to prevent injury or death, and to allow full use during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.1; 7.1.10.1; 4.5.3.2 2. Observation on 8/16/2017 at 2:51 PM in the kitchen and kitchen storage areas revealed that the doors required more than one releasing operation to open which could delay egress. Failure to maintain means of egress as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.1; 7.2.1.5.10.2 3. Observation on 8/16/2017 at 2:08 PM at the Secured Care Unit east doors revealed an exit sign above the doors with the doors opening into the direction of egress travel which could delay egress. Further observation revealed that additional exits were not located within the vicinity, which indicated that more than 50 occupants may utilize the exit in the event of an emergency. Failure to maintain means of egress as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was unaware of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.2.1; 7.2.1.4.2	K 211	1c. The East doors of the Secured Care Unit are scheduled to be fixed on 09/13/2017 so as not to open in the direction of egress travel. 2. The residents currently residing on the secure unit have the potential to be affected by this deficiency. 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that there are no barriers to egress in facility courtyards/sidewalks/gates. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/30/17 9/12/17 9/30/17 9/30/17

PRINTED: 08/31/2017
FORM APPROVED
OMB NO. 0938-0391

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

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	08/16/2017

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 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2; TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected	K 222	K222 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1a. By 09/13/2017 the signage on all the delayed egress doors will be updated to include proper door operation. 1b. On 09/05/2017 the door latches on the front door were removed. 2. All residents have the potential to be affected by this deficient practice 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that all signage remains intact. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The	9/13/17 9/5/17 9/30/17 9/12/17 9/30/17 9/30/17

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

PRINTED: 08/31/2017
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
	530024	A. BUILDING 01 - MAIN BUILDING B. WING	08/16/2017

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 222	Continued From page 3 throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 8/16/2017 at 11:12 AM in the Security Care Unit revealed that all the delayed egress doors were not provided with signage describing proper door operation. Failure to maintain delayed egress doors as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 18.2.2.2.4(2); 7.2.1.6.1.1(4) 2. Observation on 8/16/2017 at 2:42 PM at the	K 222	Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17

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

PRINTED: 08/31/2017
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	08/16/2017

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 222	Continued From page 4 main entrance revealed sliding latches at the top of the doors that could be used to lock the doors. The latches were not obvious and required more than one action to open the doors. Failure to maintain egress doors as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement.	K 222		
K 223 SS=D	REF: 2012 NFPA 101 Sections: 19.2.2.2.4; 7.2.1.5 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 19.2.2.2.7, 19.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain self closing doors in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/16/2017 at 10:50 AM in the housekeeping supervisor's supply closet revealed that the closet was being used for combustible	K 223	K223 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1a. On 08/16/2017 the wedge was removed from the housekeeping supervisor's supply closet. 2. All residents have the potential to be impacted by this deficient practice 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation.	8/16/17 9/30/17 9/12/17

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

PRINTED: 08/31/2017
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	08/16/2017

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 223	Continued From page 5 storage, and the self closing door was being held open by a wooden door wedge. Failure to maintain self closing doors as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.2.7; 7.2.1.6.1	K 223	Starting on 09/11/2017 all staff will be in-serviced on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that self-closing doors are maintained accordingly. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/30/17 9/30/17
K 227 SS=D	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a ramp in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 8/16/2017 at 2:28 PM at the ramp from the dining room revealed a dropoff of over 10 inches on the west side of the ramp with no handrail protecting that side. Failure to provide a ramp as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.6.1;	K 227	K227 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	

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

PRINTED: 08/31/2017
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	08/16/2017

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 227	Continued From page 6 7.2.5.4.2 2. Observation on 8/16/017 at 2:39 PM at the front entrance stairs revealed that the handrails on either side did not extend to the bottom two stairs. The handrails also did not have graspable dimensions. Further observation revealed that the concrete base of the west handrail had deteriorated to the point where the handrails were loose. Failure to provide stairs as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.2.2.3; 7.2.2.4.2; 7.2.2.4.4.6; 7.2.2.3.1.1	K 227	1a. The ramp adaptations will be complete by September 30, 2017. 1b. The handrails/stairs in the front of the building will be repaired by September 30, 2017. 2. All residents have the potential to be affected by this deficient practice. 3. On September 11, 2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that all handrails are secure and properly affixed. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached. K321 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of	9/30/17 9/30/17 9/30/17 9/12/17 9/30/17 9/30/17
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler	K 321		

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

PRINTED: 08/31/2017
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	08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4308 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 321	Continued From page 7 Separation, N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 8/16/2017 at 1:51 PM in the boiler room revealed that large sections of the ceiling drywall had fallen or was missing which exposed the combustible structure. The fire rating needs to be maintained at all times to prevent fire extension. Failure to maintain hazardous area enclosures as required could result in injury or death during and emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.3.2.1; 8.7.1.1; 8.3.4 2. Observation on 8/16/2017 at 2:18 PM in the Garden Creek Room revealed a large amount of combustible storage in a room greater than 50 square feet, and the door lacked a self closing device. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. Interview with the	K 321	Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1a. On 09/07/2017 the pictures of the missing drywall were sent to the Regional Director of Maintenance in order to forward to a contractor for repair recommendations. Repairs will be completed by September 30, 2017. 1b. On 09/07/2017 a self-closing door hinge was ordered and will be installed upon delivery. 2. All residents have the potential to be affected by this deficient practice 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that there are no penetrations of the fire barrier. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/30/17 9/30/17 9/12/17 9/30/17 9/30/17

PRINTED: 08/31/2017
FORM APPROVED
OMB NO. 0938-0391

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

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	08/16/2017

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 321	Continued From page 8 Facility Maintenance Manager at the time of observation indicated awareness of the requirement. ~~REF: 2012 NFPA 101 Sections: 19.3.2.1; 9.7.1.3~~	K 321	K355 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by ~~Poplar Living Center of the truth of the~~ facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual.	
K 355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 19.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 10, Standard for Portable Fire Extinguishers. The findings were: 1. Observation on 8/16/2017 at 10:28 AM in the memory care storage room revealed a portable fire extinguisher had not been inspected since April 2017. Further observation revealed additional fire extinguishers in the housekeeper supervisor office, and the med room in the main administration area had also not been inspected since April 2017. Failure to maintain portable fire extinguishers as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Sections: 19.3.5.12; 9.7.4.1 2010 NFPA 10 Section: 7.2.1.2	K 355	1a. On 09/04/2017 all fire extinguishers were inspected and dated accordingly. 1b. On 09/05/2017 the fire extinguisher was re-mounted at the appropriate height. 2. All residents have the potential to be affected by this deficient practice 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that all fire extinguishers are maintained per regulation. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds	9/4/17 9/5/17 9/30/17 9/12/17 9/30/17 9/30/17

PRINTED: 08/31/2017
FORM APPROVED
OMB NO. 0938-0391

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

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	08/16/2017

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 355	Continued From page 9 2. Observation on 8/16/2017 at 11:56 AM in the outside smoking area revealed the portable fire extinguisher was mounted at a height of 66 inches. The maximum height of mounted fire extinguishers is 60 inches. Additionally the fire extinguisher had not been inspected since April 2017. Failure to maintain portable fire extinguishers as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement.	K 355	for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. Those reports will be required until a period of compliance of 90 days is reached.	9/30/17
K 712 SS=D	REF: 2012 NFPA 101 Sections: 19.3.5.12; 9.7.4.1 2010 NFPA 10 Sections: 1.5.10; 7.2.1.2 NFPA 101 Fire Drills Fire Drills 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. The findings were:	K 712	K712 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1. There is no way to correct this past deficient practice. Fire Drills are in compliance at this time.	

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

PRINTED: 08/31/2017
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	08/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4308 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 712	Continued From page 10 Document review on 8/16/2017 at 3:00 PM revealed that the facility failed to conduct quarterly fire drills. During 2017 the facility failed to conduct a fire drill during the 2nd quarter. Failure to conduct fire drills as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement.	K 712	2. All residents have the potential to be affected by this deficient practice 3. On 09/11/2017 maintenance staff was educated on the requirements of this regulation. 4. The Director of Maintenance or designee will be responsible to report to the QA committee the time and outcome of quarterly fire drills. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	9/30/17 9/12/17 9/30/17
K 911 SS=D	REF: 2012 NFPA 101 Section: 19.7.1.6 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. The findings were: Observation on 8/16/2017 at 11:29 AM in boiler room #2 revealed that the breakers in electrical panels marked B-1, B-2 and E-2 were not labeled. Failure to maintain electrical panels as required could result in delayed electric shutdown during an emergency resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement.	K 911	K911 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1a. An appointment was set for Monday, September 11, 2017 for an electrician to	9/30/17

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

PRINTED: 08/31/2017
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	08/16/2017

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 911	Continued From page 11 REF: 2012 NFPA 101 Section: 9.1.2 2011 NFPA 70 Section: 408-4	K 911	trace the lines and label the electrical panel(s). 2. All residents have the potential to be affected by this deficient practice	9/30/17
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens	K 920	3. On 09/11/2017 maintenance staff was	9/12/17
	Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2011 NFPA 70, National Electrical Code, and 2012 NFPA 101, Life Safety Code. The findings were: Observation on 8/16/2017 at 3:52 PM in the boiler room revealed an extension cord hanging on the		educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that there are no unmarked electrical panels. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached. K920 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by Poplar Living Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response	9/30/17 9/30/17 JCA

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

PRINTED: 08/31/2017
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	08/16/2017

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 920	Continued From page 12 overhead pipes. The extension cord was plugged into a security camera, but was not plugged into an outlet. Failure to maintain electrical equipment as required could result in injury or death during an emergency. Interview with the Facility Maintenance Manager at the time of observation indicated awareness of the requirement. REF: 2012 NFPA 101 Section: 9.1.2 2011 NFPA 70 Section: 400-8	K 920	and plan of correction constitutes the facility's allegation of compliance in accordance with the state operations manual. 1. On 08/17/2017 the extension cord was removed from the pipe in the boiler room. 2. All residents have the potential to be affected by this deficient practice 3. On 09/11/2017 maintenance staff will be educated on the requirements of this regulation. Weekly environmental rounds will be completed to ensure that there are no extension cords in use. 4. The Director of Maintenance or designee will be responsible to report to the QA committee any findings of weekly rounds for review and recommendations. The Director of Maintenance or designee will be responsible to follow up on any recommendations. These reports will be required until a period of compliance of 90 days is reached.	8/17/17 9/30/17 9/12/17 9/30/17 9/30/17