STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING 01 B. WING _____	02/07/2018

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 February 7, 2018. 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 80 residents.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress for 1 of 7 exit discharges in accordance with the 2012 NFPA, Life Safety Code. The findings were:	K 211	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement	3/25/18

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

Electronically Signed | 03/02/2018

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.

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K 211	Continued From page 1 Observation on 2/7/2018 at 1:15 PM at the main entrance revealed that one of the doors had a key lock installed. Failure to maintain exit doors as required could result in injury or death during an emergency. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated that the door was never locked and that they were aware of the requirement. REF: 2012 NFPA 101, Sections: 19.2.1; 7.2.1.5.5.1	K 211	with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-211 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The double door latches/locks have been removed from the doors. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Any doors installed for means of egress will not have double door latches/locks installed on them. If the doors come with latches/locks installed the locks/latches will be removed prior to installation. How the facility will monitor its corrective actions to ensure that the deficient	

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K 211	Continued From page 2	K 211	practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will check doors with means of egress during weekly rounds. Findings will be presented at monthly QAPI meeting X3 or until deficient practice is resolved.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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	K 222		3/25/18

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K 222	Continued From page 3 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 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exits in accordance with 2012 NFPA 101, Life Safety Code. The deficiency affected 1 of 2 exit discharge doors surveyed with	K 222	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the	

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K 222	Continued From page 4 the SCU wing. The findings were: Observation on 2/7/2018 at 1:35 PM in the Secured Care Unit revealed delayed egress signage was not provided to describe delayed egress operation. Failure to post signage could delay egress through exit doors which could result in injury or loss of life. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. REF: 2012 NFPA 101, Sections 19.2.2.2.4(2); 7.2.1.6.1.1(4)	K 222	provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-222 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility has ordered a sign with the proper verbiage: Delayed Egress Door Push until alarm sounds and door can be opened in 15 seconds. Once received, the sign will be placed on the door adjacent to the releasing device. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Education re:K0222 and the requirements of proper signage on delayed egress doors.	

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K 222	Continued From page 5	K 222	Maintenance staff or designee will audit that proper signage is in place during weekly environmental rounds. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. Maintenance Director or designee will submit the audits to monthly QAPI X3 months or until the QAPI committee feels that the deficient practice has been resolved.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. The deficiency affected all emergency lighting throughout the facility. The findings were: Document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the emergency lighting had been tested on a monthly or annual basis during the previous 12 months. Failure to maintain emergency lighting as	K 291	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	3/25/18

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K 291	Continued From page 6 required could delay egress resulting in injury or death. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. During additional interview the Facility Maintenance Manager indicated that the required testing had been performed, but that they could not locate the documentation. REF: 2012 NFPA 101, Section: 19.2.9	K 291	K-291 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Paperwork from the vendor was obtained and the service was performed on 10/18/2017. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will schedule the emergency lighting check on an annual basis or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or	

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K 291	Continued From page 7	K 291	designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at monthly QAPI meeting X3 or until the deficient practice is in compliance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm and Signaling Code the deficiency affected all fire alarm systems throughout the facility. The findings were: Document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the Fire Alarm system had been inspected and tested during the previous 12 months. Failure to maintain fire alarm systems as required could result in system malfunction resulting in injury or death. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. During	K 345	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-345 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	3/25/18

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K 345	Continued From page 8 additional interview the Facility Maintenance Manager indicated that the required testing and inspection had been performed, but that they could not locate the documentation. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.2 2010 NFPA 72, Section: 14.4	K 345	The paperwork from the vendor was obtained showing the service of the fire alarm system was performed on 6/8/2017. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will schedule the fire protection system inspection on an annual basis or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at monthly QAPI meeting X3 or until the deficient practice is in compliance.	

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K 353	Continued From page 9	K 353		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire sprinkler systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 25, Inspection, Testing, and Maintenance of Water Based Fire Protection System. The deficiency affected all fire sprinkler systems throughout the facility. The findings were: Document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the fire sprinkler system had been annually inspected and tested during the past 12 months. Failure to maintain fire sprinkler systems as required could cause system failure resulting in injury or death.	K 353	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-353 What corrective action(s) will be accomplished for those residents found to	3/25/18

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K 353	Continued From page 10 Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. During additional interview the Facility Maintenance Manager indicated that the required testing and inspection had been performed, but that they could not locate the documentation. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.1 2011 NFPA 25, Section: 5.1	K 353	have been affected by the deficient practice. The paperwork from the vendor was obtained showing the service of the fire alarm system was performed on 6/8/2017. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will schedule the fire sprinkler system inspection on an annual basis or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at	

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K 353	Continued From page 11	K 353	monthly QAPI meeting X3 or until the deficient practice is in compliance.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain portable fire extinguishers in accordance with 2012 NFPA 101, and 2010 NFPA 10. The deficiency affected 3 of 20 fire extenguishers within the facility. The findings were: Observation on 2/7/2018 at 11:58 AM revealed a fire extinguisher in the Laundry Room had not been inspected during the months of December 2017 and January 2018. Further observation revealed that the fire extinguishers in the Namaste Room, and the Housekeeping office had also not been inspected in Jaunaury 2018. Failure to maintain fire extinguishers as required could result in injury or death. Interview with Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. REF: 2012 NFPA 101, Section: 9.7.4.1; 19.3.5.12 2010 NFPA 10, Section: 6.3.1	K 355	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-355 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All deficient fire extinguishers have been dated and have been brought current. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.	3/25/18

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K 355	Continued From page 12	K 355	All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will perform daily plant rounds and make sure all fire extinguishers have been dated appropriately for compliance. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. Audits will be performed by the maintenance director and/or designee on a monthly basis and will be presented at monthly QAPI meeting X3 months or until deficient practice is resolved.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		3/25/18

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(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 363	Continued From page 13 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain corridor doors in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 80, Standard for Fire Doors and Other Opening Protectives. The deficiency affected all fire doors throughout the facility. The findings were:	K 363	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The	

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	535024	A. BUILDING 01 B. WING _____	02/07/2018

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K 363	Continued From page 14 During document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the required annual fire door assembly inspection had been completed. Failure to maintain fire door assemblies as required could result in injury or death during an emergency. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. REF: 2012 NFPA 101, Section: 8.3.3.1 2010 NFPA 80, Section: 5.2.1	K 363	plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-363 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility will have fire rated doors checked by an appropriate vendor. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will schedule the fire doors to be checked on an annual basis or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued	

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K 363	Continued From page 15	K 363	effectiveness of the systemic change. The maintenance director and/or designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at monthly QAPI meeting X3 or until the deficient practice is in compliance.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741		3/25/18

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K 741	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoking provisions according to the 2012 NFPA 101, Life Safety Code. The deficiency affected 1 of 1 smoking areas. The findings were: Observation on 2/7/2018 at 11:06 AM outside in the smoking area revealed several cigarette butts discarded into a combustible trash can. Further observation revealed that the trash can was full of combustible trash, and was leaning against the building. Failure to maintain smoking provisions as required could result in a fire resulting in injury or death. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. REF: 2012 NFPA 101, Section: 19.7.4	K 741	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-741 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Trash cans were emptied the day that cigarette butts were found inside. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	

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K 741	Continued From page 17	K 741	Maintenance Director and/or designee will perform rounds in the designated smoking area to make sure that cigarette butts are not in noncombustible trash containers. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will monitor for compliance on a daily basis. Findings will be presented at the monthly QAPI meeting X3 or until the QA team feels deficient practice is effectively corrected.	
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain portable heaters in accordance with the 2012 NFPA 101, Life Safety Code. The deficiency affected 3 of 120 rooms surveyed. The findings were: Observation on 2/7/2018 at 10:59 AM in the Activities Room revealed an electric portable	K 781	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	3/25/18

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K 781	Continued From page 18 heater. Further observation revealed additional portable heaters in the entrance to the Smoking Area, and the Laundry Room. Failure to maintain portable heaters as required could result in a fire causing injury or death. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were aware of the requirement. REF: 2012 NFPA 101, Section: 19.7.8	K 781	executed solely because it is required by the provisions of federal and state law. K-781 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All portable space heaters were removed from facility. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance Director and/or designee will perform daily physical plant rounds to make sure there are no space heaters within the facility that do not meet 2012 NFPA 101 and Life Safety Code. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued	

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K 781	Continued From page 19	K 781	effectiveness of the systemic change. The maintenance director and/or designee will perform audits weekly and present findings at monthly QAPI meeting X3 or until the QAPI team feels the deficient practice is effectively corrected.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		3/25/18

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K 918	Continued From page 20 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, the 2010 NFPA 110, Standard for Emergency and Standby Power Systems, and the 2012 NFPA 99, Health Care Facilities Code. The deficiency affected 1 of 1 generators. The findings were: Document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the emergency generator had been exercised under load during the previous 12 months. Emergency generators shall be load tested either monthly or annually to insure proper operation during an emergency. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. REF: 2012 NFPA 101, Section: 9.1.3.1 2010 NFPA 110, Section: 8.4.2; 8.4.3 2012 NFPA 99, Section: 6.4.1.1	K 918	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-918 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The paperwork from the vendor was obtained showing the service of the emergency generator system was performed on 8/7/2017. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient	

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K 918	Continued From page 21	K 918	practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The maintenance director and/or designee will schedule the emergency generator system inspection on an annual basis or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at monthly QAPI meeting X3 or until the deficient practice is in compliance.	
K 932 SS=E	Features of Fire Protection - Other CFR(s): NFPA 101 Features of Fire Protection - Other List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection 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 15 (NFPA 99)	K 932		3/25/18

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K 932	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain fire alarm systems in accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 80, Standard for Fire Doors and other Opening Protectives. The deficiency affected all fire dampers throughout the facility. The findings were: Document review on 2/7/2018 at 2:00 PM revealed that the facility could not verify that the Fire Dampers had been inspected and tested during the previous 4 years. Failure to maintain Fire Dampers as required could cause smoke and fire spread resulting in injury or death. Interview with the Facility Administrator and Facility Maintenance Manager at the time of observation acknowledged the deficiency, and indicated they were unaware of the requirement. REF: 2012 NFPA 101, Section: 8.4.6.2 2010 NFPA 80, Section: 19.4.1.1	K 932	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K-932 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility has notified vendor to schedule an appointment for the fire dampers to be inspected. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents, in some form and at some time, could be at potential risk to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.	

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K 932	Continued From page 23	K 932	The maintenance director and/or designee will schedule the fire dampers to be checked every four (4)years or as needed for any repairs. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. The maintenance director and/or designee will keep vendor documentation on the facilities internal record system to make sure documentation is available for review. Any findings will be presented at monthly QAPI meeting X3 or until the deficient practice is in compliance.	

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on February 7, 2018. Based upon the findings of the survey team, it was determined the facility was in compliance with all Emergency Preparedness requirements.	E 000		

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.