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 _____	**01/08/2019**

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 January 8, 2019. 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 67 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 the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress as required could delay egress from the building	K 211	Immediate Correction: Facility staff moved the door magnet to the center of the door on 1/9/2019. Facility maintenance staff and other staff tested the door and easily opened with	1/31/19

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K 211	Continued From page 1 during an emergency resulting in injury or death. The deficiency affected 1 of approximately 7 exits. The findings were: Observation on 1/08/2019 at 10:55 AM at the southeast exit revealed an exterior door that required more than 30 pounds of force to set the door in motion. Interview with the facility maintenance staff at the time of observation acknowledged the door exceeded 30 pounds of force to open, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.1; 7.2.1.4.5 .	K 211	minimal force. Identification of Others: To ensure the potential to not be affected by the same deficient practice, maintenance staff will perform weekly door tests and will be documented in the TELS program. System Measures: Weekly testing will be performed to ensure the deficient practice doesn't occur. The TELS program will include documented testing. Monitor: Reporting of the testing will be presented and reported to the Safety Committee, monitored and reporting to the monthly QAPI committee.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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 or 19.3.5.9. 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.	K 321		1/31/19

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K 321	Continued From page 2 19.3.2.1, 19.3.5.9 Area Separation N/A Automatic Sprinkler 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 REQUIREMENT 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. Failure to maintain hazardous areas as required could result in injury or death during an emergency. The deficiency affected 1 of numerous rooms in the facility. The findings were: Observation on 1/08/2019 at 10:50 AM in room 610 revealed a large amount of combustible storage in a room greater than 50 square feet, and the door lacked a self closing device. Interview with the facility maintenance staff at the time of observation acknowledged the storage, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2; 19.3.2.1.3 .	K 321	Immediate Correction: All combustible material was removed from room 610 on 01/30/2019. Identification of Others: All resident and storage rooms will be inspected for compliance with the life safety code and will be completed by 2/8/2019. Resident Council will be notified of the inspection at their next meeting to ensure residents understand the storage and use of combustible materials and the limit allowed. System measures: Informational material and acknowledgement will be included in the facility admission packet effective 2/1/2019. All other residents and staff will be provided with the informational material and acknowledgement by 2/8/2019.	

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K 321	Continued From page 3	K 321	Monitoring: Maintenance staff will randomly audit three to five resident rooms and other areas monthly for the next six (6) months, and then randomly audit three to five resident rooms and other areas every six (6) months. If any areas contain combustible materials more than what is allowed, materials will be removed immediately.	
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. Failure to maintain fire alarm systems as required could result in injury or death during an emergency. The deficiency affected 1 of 3 (alarm initiating, supervisory alarm initiating, and notification) testing requirements of the fire alarm system. The findings were: Document review on 1/08/2019 at 3:00 PM revealed the facility could not verify that each horn and strobe notification device had passed	K 345	Immediate Correction: Facility is currently waiting for a revised bid from local vendor to replace wiring for all horn and strobe in the facility. Identification of Others: Once vendor completes work, deficiency will be corrected for the entire facility. System measures: Monthly testing during fire drills will ensure a systematic change has occurred. Monitor:	4/1/19

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K 345	Continued From page 4 visual and audible inspection during the previous 12 months. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.4.1; 9.6.1.5 2010 NFPA 72, Sections: 14.4.5(20); 14.6.2.4; Figure 14.6.2.4 page 11 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. Failure to maintain fire alarm systems as required could result in injury or death during an emergency. The deficiency affected (1) of (2) testing requirements for smoke detection equipment. The findings were: Document review on 1/08/2019 at 3:00 PM revealed the facility could not verify that a smoke detector sensitivity test had been conducted during the previous 24 months. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.4.1; 9.6.1.5	K 345	Testing reports will be submitted through the Safety Committee and reported monthly to the QAPI Committee.	

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K 345	Continued From page 5 2010 NFPA 72, Sections: 14.4.5.3	K 345		
K 353 SS=D	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 observation 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, Standard for the Inspection, Testing and Maintenance of Water-Based Protection Systems. Failure to maintain fire sprinkler systems as required could result in injury or death during an emergency. The deficiency affected less than 10 percent of the attic area of the facility. The findings were: Observation on 1/08/2019 at 1:30 PM above	K 353	Immediate Correction: Maintenance staff cleared insulation from sprinkler head over hallway 2 on 1/18/19. Identification of Others: Maintenance staff inspected all sprinkler heads in the facility attic and corrected any that were deficient on 1/18/2019. System Change: Periodic detailed inspections of the attic will occur not to exceed every six months.	1/18/19

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K 353	Continued From page 6 hallway 2 revealed attic insulation falling down and obstructing the fire sprinkler heads. Further observation in other areas of the attic did not reveal additional areas of concern. Interview with the facility maintenance manager at the time of observation acknowledged the falling insulation, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.5.1; 9.7.5 2011 NFPA 25, Section: 5.2.1.1.1	K 353	Inspections will be documented in the comment section of fire wall inspection in the TELS program. Monitor: Reports of inspections will be provided to the Safety Committee and reported to the QAPI committee as required.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain subdivision of building spaces in accordance with the 2012 NFPA 101,	K 372	Immediate Correction: Maintenance staff covered 6 inch hole with fire putty on 1/18/19.	1/31/19

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K 372	Continued From page 7 Life Safety Code. Failure to maintain subdivision of building spaces as required could result in fire spread resulting in injury or death. The deficiency affected 1 of approximately 5 smoke/fire barriers in the facility. The findings were: Observation on 1/08/2019 at 1:30 PM above hallway 2 in the attic area revealed a 6 inch penetration in the fire barrier which had not been sealed. Interview with the facility maintenance staff revealed ethernet cables passed through the penetration. Further observation in other areas of the attic revealed no other visible unsealed penetrations in any other fire or smoke barrier. Interview with the facility maintenance manager at the time of observation acknowledged the penetration, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 8.3.4; 8.3.5 .	K 372	Identification of Others: Maintenance staff inspected all firewalls in the facility attic and corrected any that were deficient on 1/18/2019. System Change: Periodic detailed inspections of the attic will occur not to exceed every six months. Inspections will be documented in the comment section of fire wall inspection in the TELS program. Monitor: Reports of inspections will be provided to the Safety Committee and reported to the QAPI committee as required.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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) assembles 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	K 920		1/31/19

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K 920	Continued From page 8 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment in accordance with the 2012 NFPA 101, Life Safety Code, and the 2011 NFPA 70, National Electrical Code. Failure to maintain electrical equipment as required could result in injury or death during an emergency. The deficiency affected 1 of numerous rooms in the facility. The findings were: Observation on 1/08/2019 at 11:10 AM in the business office revealed a power strip plugged into another power strip creating a daisy chain. Interview with the facility maintenance staff at the time of observation acknowledged the daisy chain, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 9.1.2 2011 NFPA 70, Section: 400-8	K 920	Immediate Correction: Disconnected all daisy chained power strips in the business office and plugged into wall outlets on 1/9/2019. Identification of Others: Maintenance staff will inspect all facility for any other deficiencies and completed on 1/10/2019. All deficiencies were corrected as needed during the inspection. System change: Education to staff occurred on 1/31/2019 at monthly staff meeting. Education will continue during routine inspections of offices and resident rooms. Monitor: Report to Safety Committee on deficiencies found during inspection. Safety Committee will report to QAPI Committee in February for any additional	

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K 920	Continued From page 9	K 920	monitoring and outcomes.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on January 8, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000		

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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.