SEP 15 2008

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

PRINTED: 09/08/2008
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 ______	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST CASPER, WY 82601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction built in 1967 and 1973. The building was equipped with an supervised automatic wet sprinkler system and anti-freeze branch with a zoned fire alarm system.	K 000	POC accepted w/ [illegible] 9/24/08. [signature]	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in two of eight smoke compartments. The findings were: 1. Observation on 8/25/08 at 2:49 PM revealed paper products were being stored in the kitchen dry storeroom. The door to the dry storeroom was	K 029	K-029 No residents were affected by this alleged deficiency. 1. A door closer will be installed on the kitchen dry storage door. Routine inspection and in-service meetings will be conducted to ensure proper procedures are kept. Documentation will be presented to QA Committee for continued compliance and recommendations x3 months. 2. Hall #2 soiled utility closet will be adjusted and door closer will be adjusted and or replaced to solve this deficiency. ~~Regular~~ [quarterly] inspection and documentation will continue in our records. See attached #1	10-9-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 9/10/08

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.

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 _____	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 029	Continued From page 1 not equipped with an automatic closing device. Interview with the maintenance director at the time of observation revealed all hazardous areas were inspected monthly to ensure proper separation. 2. Observation on 8/25/08 at 4:37 PM revealed the automatic-closing device attached to the hall #2 soiled utility corridor door did not latch the door into it's frame, with three repeated attempts.	K 029	K-062 No Residents were harmed or affected by these alleged deficiencies. 1. Both hall #6 shower room sprinkler heads will be replaced with like or acceptable replacements according to NFPA 13. All sprinkler heads in high humidity areas will be inspected and replaced as needed. 2. The sprinkler head in the Director of Marketing office will be lowered to meet NFPA 13 requirements. All sprinkler heads will be inspected as to proximity to all light fixtures and lowered or repositioned as needed 3. The sprinkler head in the Activities office shall be moved to a min of 4" from the wall to meet NFPA 13 requirements.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the sprinkler system was properly maintained in two of eight smoke compartments. The findings were: 1. Observation on 8/25/08 at 3:10 PM revealed both of the sprinkler heads in the hall #6 shower room were corroded. Interview with the maintenance director at the time of observation revealed the sprinkler system was inspected annually. 2. Observation on 8/25/08 at 3:50 PM revealed one of two sprinkler heads in the director of marketing office was obstructed by a newly installed fluorescent light cover. 3. Observation on 8/26/08 at 9:10 AM revealed	K 062		10-9-08

- QA Committee Review
Monthly x3.

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 _____	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 062	Continued From page 2 one of four sprinkler heads in the activities office was less than four inches from the wall. The head was only one inch from the wall.	K 062		
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure window curtains were flame retardant in one of eight smoke compartments. The findings were: 1. Observation on 8/25/08 at 2:32 PM revealed the curtains in the health information managers office did not have labels indicating the curtains were flame retardant. Interview with the maintenance director at the time of observation	K 074	K-074 No Residents were harmed or affected by this alleged deficiency. 1. The curtains in the HR office will be treated as per NFPA 13 code standards. The Fire retardant spray log will be updated and submitted to QA monthly x 3. see attachment #2	10-9-08

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 _____	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 074	Continued From page 3 revealed all curtains were inspected monthly to ensure they were flame retardant. 2. Review of the applied flame retardant spray log revealed no entry had been made for the curtains in the health information office.	K 074		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two of two liquid oxygen storerooms were equipped with required safety features. The findings were: 1. Observation on 8/25/08 at 2:18 PM revealed the exhaust fan in the hall #1 liquid oxygen storeroom was equipped with an on/off switch. The fan had been turned off while liquid oxygen	K 143	K-143 No Residents were harmed or affected by this alleged deficiency. 1. The exhaust fans disconnect was installed for Maintenance safety per OSHA. The disconnect will be enclosed in a securable box to ensure no further unauthorized removal of fan from service. 2. The light switches as indicated in paragraph 2 will be moved from existing 48" to the new required height of 60" as per NFPA requirements. - QA. Committee Review Monthly x3.	10-9-08

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 _____	08/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 143	Continued From page 4 tanks were being stored in the room. 2. Observation on 8/25/08 at 3:22 PM revealed the light switch in the hall #6 liquid oxygen room was not 60 inches above the floor. The light switch was only 48 inches above the floor.	K 143		