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

RECEIVED JUL 27 2007 Wyoming Dept. of Health Licensure and Survey

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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	06/27/2007

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. The facility was a fully sprinklered single story building of Type V (111) construction built in 1967 and 1972. The building was equipped with a supervised automatic wet sprinkler system and fire alarm system.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. JM approved with changes indicated on 8/2/07 ē administrator Arloa Johnson by phone 0954. This STANDARD is not met as evidenced by:	K 018	1. No residents were affected by this ~~alleged~~ JM deficient practice. 2. Resident room doors (310 & 512) will be repaired. Resident room 413 door guard will be repaired. Resident room doors (402 & 406) will have the isolation racks removed and relocated. 3. The Maintenance Supervisor (MS) will establish and complete a Door Serviceability inspection form to address all door operations, this is to include serviceable doorknobs, latches, hinges, smoke gap, closures, holes, jam protectors and door protectors. 4. Random reviews of all doors will be conducted by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall monitoring of compliance by QA&A committee	8/11/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Revised POC Arloa W Johnson

TITLE: NHA

(X6) DATE: 7-26

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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 018	Continued From page 1 Based on observation the facility failed to maintain 5 of 124 corridor doors. The findings were: 1. Observation 6/27/07 between 2:30 PM and 3 PM revealed the following locations had corridor doors that were equipped with latch bolts that would not insert into the strike plates of their respective door frames: a. Resident room #310. b. Resident room #612. 2. Observation on 6/27/07 between 1:30 PM and 2 PM revealed the following corridor doors were impeded: a. The corridor door to resident room #413 was obstructed by the door frame plastic guard. b. The corridor door to resident room #406 was obstructed by an isolation supply rack hanging over the door. c. The corridor door to resident room #402 was obstructed by an isolation supply rack hanging over the door.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025	1. No residents were affected by this ~~alleged~~ deficient practice. 2. The attic barrier walls on the 100, 500 & 600 wings will be resealed at the penetrations. 3. The Maintenance Supervisor will establish and complete an Attic Barrier Wall Penetration inspection check form to address all life safety issues to include new construction, construction ~~contractor~~ in attic area and any ~~noted~~ unsealed penetrations. 4. Random reviews of attic barrier walls will be conducted by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed ~~for~~ continued compliance (x3 months and as needed. 5. Overall compliance will be monitored by QA+A committee.	8/11/07

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K 025	Continued From page 2 Based on observation the facility failed to seal penetrations in 3 of 8 vertical smoke barrier walls. The findings were: Observation on 6/27/07 between 3 PM and 4 PM revealed the following vertical smoke barrier walls had unsealed penetrations: a. The 100 hall attic smoke barrier wall had 2 unsealed cable penetrations. b. The 500 hall attic smoke barrier wall had 2 unsealed cable penetrations. c. The 600 hall attic smoke barrier wall had 3 unsealed cable penetrations.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain 2 of 24 smoke barrier doors. The findings were: Observation on 6/27/07 at 1:51 PM revealed the cross corridor smoke barrier double doors near resident room #402 could not be completely closed as required. According to NFPA 101 Section 8.3.4.1 "Doors in	K 027	1. No residents were affected by this ~~alleged~~ deficient practice. 2. The smoke barrier double doors near resident room 402 will be repaired. 3. The Maintenance Supervisor (MS) will establish and complete a Door Serviceability inspection form to address all door operations, this is to include serviceable doorknobs, latches, hinges, smoke gap, closures, holes, jam protectors and door protectors. 4. Random reviews of all doors will be conducted by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall compliance will be monitored by QA+A committee.	8/11/07

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K 027	Continued From page 3 smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles."	K 027		
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 the facility failed to maintain the self-closing devices attached to the corridor doors for 5 of 18 hazardous rooms. The findings were: Observation on 6/27/07 between 2 PM and 3 PM revealed the self-closing devices on the following locations had corridor doors that did not fully latch the doors into their respective door frames: a. The 200 hall soiled utility room. b. The 400 hall soiled utility room. c. The 500 hall soiled utility room. d. The copy room. e. The special care unit nurses' supply closet.	K 029	1. No residents were affected by this ~~alleged~~ deficient practice 2. The copy room door, the special care nurse's supply closet door & the soiled utility room doors on the 200, 400 & 500 halls will be adjusted, repaired or replaced as needed. 3. The Maintenance Supervisor (MS) will establish and complete a Door Serviceability inspection form to address all door operations, this is to include serviceable doorknobs, latches, hinges, smoke gap, closures, holes, jam protectors and door protectors. 4. Random reviews of all doors will be conducted by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall compliance will be monitored by the QA+A committee	8/11/07
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	Continued From page 4 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct fire drills on 3 of 12 quarterly shifts in the past year and failed to conducted fire drills at varying times. The findings were. 1. Review of the fire drill records revealed the night shift had not conducted fire drills during the second and fourth quarters of 2006 or the first quarter of 2007. 2. Review of the fire drill records revealed the night shift had conducted 3 of 4 fire drills between 5:45 AM and 6:45 AM and not at varying times throughout the shift. 3. Interview with the environmental care service director on 6/27/07 at 1 PM revealed he thought the night shift ended at 7 AM. The Director of Nursing confirmed the night shift ended at 6 AM. 4. Review of the fire drill records revealed the drills conducted on the morning shift had not been at unexpected times as all the drills had occurred between 10 AM and 11 AM in the past year.	K 050	1. No residents were affected by this ~~alleged~~ deficient practice 2. The Staff Development Coordinator will coordinate with the Nursing Scheduler to conduct random fire drills during each shift. 3. The Administrator will review all fire drills to monitor for randomness of times and to ensure that all shifts are covered. 4. Random fire drills will be conducted by the Staff Development Coordinator or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall compliance will be monitored by the QA+A committee.	8/11/07
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		

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K 056	Continued From page 5 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure 2 of 7 sprinkler heads located in the kitchen were installed as required. The findings were: Observation on 6/27/07 at 1:42 PM revealed 2 sprinkler heads were only 4 feet apart. According to NFPA 13 Section 5-6.3.4 "Sprinklers shall not be less than 6 ft on center."	K 056	1. No residents were affected by this ~~alleged~~ deficient practice 2. The Maintenance Supervisor will remove/relocate the fire sprinkler in the kitchen to ensure proper coverage. 3. The Maintenance Supervisor will monitor all new construction and remodeling projects to ensure that correct sprinkler coverage is maintained. 4. All new construction and remodeling will be monitored by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed 5. Overall compliance will be monitored by the QA+A committee.	8/11/07
K 074 SS=D	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	K 074		

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K 074	Continued From page 6 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 and staff interview, the facility failed to maintain documentation of flame retardancy for curtains in 1 of 6 tub rooms. The findings were: 1. Observation on 6/27/07 at 2:50 PM revealed the 200 hall tub room had a window curtain that did not have flame retardant documentation attached to it. 2. Interview with the environmental care service director on 6/27/07 at 2:50 PM revealed the curtains were newly installed and the facility had documentation to review.	K 074	1. No residents were affected by this ~~alleged~~ deficient practice 2. The flame retardant documentation is attached for your review. The Maintenance Supervisor will maintain a Flame Retardant Documentation file to ensure easy access to all required information. 3. The Maintenance Supervisor will monitor all new construction and remodeling projects to ensure that NFPA 13 standards are met is maintained. 4. All new curtains will be monitored by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall compliance will be monitored by QA+A Committee.	8/11/07
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA.70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to prohibit flexible wiring replacing temporary fixed wiring in 1 of 110 rooms and failed to provide an emergency battery light at the automatic transfer switch (ATS). The findings were: 1. Observation on 6/27/07 at 1:33 PM revealed	K 147		

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K 147	Continued From page 7 the resident room #113 had an extension cord attached to the wall. The environmental care service director reported the housekeeping staff was supposed to monitor the resident rooms for extension cords. He stated every room in the facility was inspected for extension cords semi-annually. 2. Observation on 6/27/07 at 1:21 PM revealed the automatic transfer switch (ATS) was not equipped with an emergency battery light. According to NFPA 70 Article 517-32 "...The life safety branch of the emergency system shall supply power for the following lighting, receptacles, and equipment. (e) Generator Set Location, task illumination battery charger for emergency battery-powered lighting unit(s) and selected receptacles at the generator set location.	K 147 Rq 3 Rene P.E. CMS	1. The maintenance Supervisor immediately removed the extension cord 2. All staff will be in-serviced as to life safety items that they may become in contact with. A facility wide inspection was conducted to monitor for additional extension cords. 3. The maintenance supervisor or designee will monitor all life safety items during his/her monthly safety inspections and document utilizing the safety inspection check form. 4. All audits will be completed by the Maintenance Supervisor or designee and reported to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months and as needed. 5. Overall compliance will be monitored by QA+A committee. To address paragraph 2: This facility respectfully requests an extension to correct the battery powered illumination requirements to the generator and the transfer switch (see attached)	8/11/07 10/24/07