POC accepted 12/27/10 JL

PRINTED: 12/08/2010
FORM APPROVED

WDH - Office of Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | WY0023 | A. BUILDING _____ B. WING _____ | 11/18/2010 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| SNH | LIC REGS FOR NURSING HOMES<br><br>This State Rules and Regulations is not met as evidenced by:<br>WYOMING DEPARTMENT OF HEALTH AND AGING DIVISION<br>Rules and Regulations for Program Administration of Nursing Care Facilities<br>Chapter 11<br><br>Section 5 Organization and Administration<br>(b) (iv) (A) Tuberculin testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter.<br><br>This rule was not met as evidenced by:<br><br>Based on staff interview and review of personnel records, the facility failed to ensure tuberculin testing was completed prior to resident contact for 3 of 5 employees reviewed. The findings were:<br><br>Review of personnel files revealed the following employees did not have evidence of tuberculin testing: a nurse aide hired 9/23/10; the staff development coordinator hired 10/29/10; and a CNA hired 9/28/10. During an interview on 11/18/10 at 8:15 AM, the staff development coordinator stated she was not able to find evidence of tuberculin testing for the employees.<br><br>Section 11, Dietetic Services<br><br>1. (a)(i) If the qualified supervisor is not a Registered Dietitian, S/he shall be a graduate of a dietetic technician program approved by the American Dietetic Association or a dietary | SNH | SNH Section 5:<br>It is the practice of the facility to ensure that Tuberculin testing shall be accomplished for each employee upon employment and before resident contact begins and annually thereafter.<br><br>Corrective Action:<br>The said stated employees; one nurse aide hired 9/23/10, one Staff Development Coordinator hired 10/29/10 and one Certified Nurses Assistant hired 9/28/10 were administered the Tuberculin Testing respectively; Administered August,2010 as part of the Certified Nurses Assistant class outside of this facility. 11-19-10,the third employee terminated employment with this facility on 11-24-10.<br><br>Identification of others:<br>1.Current Employee files will be reviewed for compliance to Tuberculin testing by the SDC/designee.<br>2.Any employees found to not be in compliance to Tuberculin testing will have the testing administered by the SDC/designee.<br><br>Systemic Changes:<br>1.All new employees will be administered Tuberculin testing by the SDC/designee upon employment and before resident contact begins.<br>2.All current employees Tuberculin records will be maintained by the SDC/designee in a way to ensure that annual testing is completed.<br>3.DON/designee will monitor SDC records of employee testing for compliance monthly.<br><br>Monitoring:<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by DON/designee. The QA&A committee will | |

Wyoming Dept of Health, Office of Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/13/10

STATE FORM 6899 — TQTE11 — If continuation sheet 1 of 2

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Wyoming Dept of Health
DEC 13 2010
Office of Healthcare Licensing and Surveys

Changes made per phone conversation with Dawn Tofano, Administrator on 12/27/10 @ 8:04 am
Janelle Cook, ONLC

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FORM APPROVED

WDH - Office of Healthcare Licensing and Surveys

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | WY0023 | A. BUILDING _____ B. WING _____ | 11/16/2010 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| SNH | Continued From page 1<br><br>managers' educational program approved by the Certifying Board for Dietary Managers. Training and experience in food service supervision and nutrition equivalent in content to the approved educational programs are acceptable.<br><br>This standard was not met as evidenced by:<br>Based on staff interview and review of course information, the facility failed to ensure the minimum qualifications were met for the dietary manager. The findings were:<br><br>Interview with the dietary manager on 11/16/10 at 3:16 PM revealed she was still enrolled in the certification program through the University of North Dakota. However, she stated she would be unable to meet the expected graduation date of 12/17/10. The manager revealed she was planning to get a 6 month extension that was available making the new expected graduation date 6/17/11. Interview with the registered dietitian (RD) who was also the program preceptor confirmed this date, and stated the manager was making progress. Review of course information provided by the facility further verified the expected date with the six month extension. | SNH | evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months.<br><br>Corrective Date:<br>To be completed on or before 12/31/10<br><br>SNH Section 11:<br>It is the practice of the facility to ensure that if the qualified supervisor is not a Registered Dietitian, s/he shall be a graduate of a dietetic technician program approved by the American Dietetic Association or a dietary managers' educational program approved by the Certifying Board for Dietary Managers. Training and experience in food service supervision and nutrition equivalent in content to the approved educational programs are acceptable.<br><br>Corrective action:<br>Dietary Manager is currently enrolled in the certification program through the University of North Dakota. She will complete the course and graduate by 6/17/11. Facility will submit monthly progress report to OHLS.<br>Identification of Others:<br>Only the Dietary Manager is involved.<br><br>Systemic Changes:<br>The Registered Dietician will monitor the progress of the Dietary Manager's progress with the education process to ensure that the education is completed by the above stated date.<br><br>Monitoring:<br><br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the QA&A committee by the Dietary Manager/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly times 3 months.<br><br>Corrective Date:<br><br>Education completion on or by June 17, 2011 | 12/31/10<br><br>6/17/11 |