PRINTED: 12/04/2007
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 11/21/2007

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
F 203 SS=D	483.12(a)(4)-(6) TRANSFER AND DISCHARGE REQUIREMENTS	F 203		

Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.

Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.

The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental

F 203 Transfer and Discharge Requirements

Resident #1 no longer resides at the facility

Residents discharging from the facility have the potential to be affected by the ~~alleged~~ deficient practice.

The Interdisciplinary team (IDT) and licensed nurses will be in-serviced ~~on (date)~~ regarding Transfer and Discharge Requirements. The transfer/discharge requirements training will encompass resident and/or caregiver notification, the inclusion of the reason for transfer/discharge, the resident's right to appeal, and the names, addresses and telephone numbers for the ombudsman, as well as the protection and/or advocacy agencies, if appropriate. The medical record documentation requirements for transfer/discharge will be included in this training.

1-4-2008

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlon W Johnson | TITLE: NHA | (X6) DATE: 12-12-07

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.

Accepted w/ changes per phone call w/ Arlon Johnson NHA 12 2007

on 12/27/07 DOC: 1/4/08

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F 203	Continued From page 1	F 203		

disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, and staff interview, the facility fail to provide a written notice as required for one (#1) of one sample resident who the facility discharged. The findings were:

Review of nurses' notes dated 7/8/07 for resident #1 revealed the resident left the facility after combative aggression toward staff and residents. Staff documented the resident's family member was notified by phone that the resident could not return due to safety concerns for staff and other residents. Social service notes dated 7/9/07 documented the resident had an episode of agitation and aggression and could not return "without admin. [administrator] permission." Review of the facility policy titled, "Transfer & Discharge", dated June 2007, #OP2 0209.00, revealed it defined "discharge" as moving the resident to a non-institutional setting such as home, or discharge without expectation of return and transfer as "return anticipated." It documented that when a residents's urgent medical needs require more immediate transfer

The Interdisciplinary Team will review each resident's medical record prior to discharge and document a summary of the information related to the resident's notification and preparation for discharge.

The Health Information manager will conduct an audit of discharged residents medical records. The Health Information Manager or designee will report the trended results of the audits to the QA&A committee monthly for review and recommendation for further action. The QA&A committee will continue monthly reviews of this information for three months or until the committee determines that the facility has maintained compliance with this regulatory requirement.

If Emergency discharge the IDT will complete a Summary of the info Re: to the discharge as soon as possible

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F 203	Continued From page 2 or discharge, the facility would provide notice, which included reason for transfer/discharge, resident rights information, and advocacy information, as soon as practicable. Interview with the administrator on 11/19/07 at 3:27 PM revealed the facility refused to accept the resident back due to safety concerns for staff and other residents. The administrator stated the resident was not given a 30 day notice due to the urgent need to remove the resident from the facility. During a second interview on 11/21/07 at 10:17 AM the administrator confirmed neither the resident nor family received written information with regard to the reason for discharge, right to appeal, or advocacy information.	F 203	**F283 Discharge Summary** ~~Resident #2 no longer resides at the~~ facility. Residents discharging from the facility have the potential to be affected by the ~~alleged~~ deficient practice.	
F 283 SS=D	483.20(l)(1)&(2) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a recapitulation of stay for one (#2) of one sample resident who was discharged to home. The findings were: Review of the medical record for resident #2 revealed social service notes dated 7/11/07 in which the plan for discharge was for the resident to return home. Nurses' notes dated 7/25/07 at 6	F 283	The Interdisciplinary Team and licensed nurses will be in-serviced ~~on (date)~~ regarding the discharge requirements (prior to discharge), to include a recapitulation of the resident's stay, a final summary of the resident's status and a post-discharge plan of care which is then given the resident and/or caregiver, as well as all other agencies planning to assist the resident following discharge.	

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F 283	Continued From page 3 PM documented the resident was discharged to home. Review of documentation failed to reveal a recapitulation of stay. Interview with the administrator on 11/21/07 at 10:55 AM revealed staff review of the record failed to find a recapitulation of stay.	F 283	The Interdisciplinary Team, resident, and/or caregiver will review the resident's completed discharge plan of care. **The recapitulation of the resident's stay, a final summary of the resident's status** and a post-discharge plan of care will be documented in the resident's medical record. The post-discharge plan of care will describe the resident's and family's preferences for care, how the resident and family will access community based services and how the resident's care should be coordinated if his or her continuing treatment involves multiple caregivers. This documentation, information related to discharge, will be made available to the resident, caregivers or other appropriate agencies. The Health Information Manager will conduct an audit of discharged resident's medical records. The Health Information Manager or designee will report the trended results of the audits to the QA&A committee monthly for review. The QA&A committee will continue monthly review of this information for three months or until the	
F 284 SS=D	483.20(l)(3) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and staff interview, the facility failed to ensure discharge care planning occurred for one (#2) of one sample resident with a planned discharge to home. The findings were: Review of the medical record for resident #2 revealed social service notes dated 7/11/07 in which the plan for discharge was for the resident to return home. Nurses' notes dated 7/25/07 at 6 PM documented the resident was discharged to home with discharge instructions "given". The notes documented the resident was on 2 liters of oxygen at the time of discharge. However, there were no details provided in the note regarding a plan of care. Review of the facility policy titled, "Transfer & Discharge", dated June 2007, #OP2 0209.00, showed when a planned resident discharge occurred, a post-discharge plan would be developed prior to the resident discharge. Interview with the administrator on 11/21/07 at	F 284		

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10:55 AM reveal the medical record did not have a discharge plan of care.

family's preferences for care, how the resident and family will access community based services and how the resident's care should be coordinated if his or her continuing treatment involves multiple caregivers. The resident's needs after discharge, such as personal care, sterile dressings, therapy, medication regime, and educational needs are also included in the post-discharge plan of care to assist the resident to adjust to his or her new living environment. This documentation, information related to discharge, will be made available to the resident, caregivers or other appropriate agencies.

The Health Information Manager will conduct an audit of discharged resident's medical records. The

Health Information Manager or designee will report the trended results of the audits to the QA&A committee monthly for review. The QA&A committee will continue monthly review of this information for three months or until the committee determines that the facility has maintained compliance with this regulatory requirement.

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Resident #2 no longer resides at the facility.

Residents discharging from the facility have the potential to be affected by the alleged deficient practice.

The Interdisciplinary Team and licensed nurses will be in-serviced ~~on (date)~~ regarding the discharge requirements (prior to discharge), to include a recapitulation of the resident's stay, a final summary of the resident's status and a **post-discharge plan of care** which is then given the resident and/or caregiver, as well as all other agencies planning to assist the resident following discharge.

The Interdisciplinary Team, resident, and/or caregiver will review the resident's completed discharge plan of care. The recapitulation of the resident's stay, a final summary of the resident's status and a **post-discharge plan of care** will be documented in the resident's medical record. The post-discharge plan of care will describe the resident's and 1-4-2008

1-4-2008