POC accepted 7/7/08
Janelle Cook, ORN/L

DEPARTMENT OF HEALTH AND HU...AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/23/2008
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 _____ B. WING _____	C 06/12/2008

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
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	F225 – Staff Treatment of Residents The $15.00 was refunded to resident #6 on 6/12/08 The last 4 months of grievances and/or allegations of misappropriation of resident property have been reviewed by IDT team to ensure incidences have been investigated and all officials in accordance with state law have been notified. JC 7/9/08 Grievances and/or misappropriation of funds will be reviewed at the AM meeting daily to ensure that no abuse, neglect and/or misappropriation of resident property has not occurred and appropriate follow up has been completed. . Educations completed by 7/9/08 for employees on resident rights, abuse/neglect and misappropriation of resident's property. Audits to be conducted on all grievances and allegations of abuse/misappropriation of resident's property, daily for one month and weekly for 2 months and missing items to be investigated within 5 working days. Trending and tracking will be done on a weekly basis and taken to QA & A to be reviewed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Tofano | TITLE: Administrator | (X6) DATE: 7/2/08

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. Changed mode per phone call with Dennis Tofano, Adm on 7/7/08 @ 1330.

Wyoming Dept of Health
Licensing and Surveys
JC

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F 225	Continued From page 1 by: Based on staff interview and review of grievances and internal investigations, the facility failed to report one of one allegations of theft from sample resident #6 to the proper officials in accordance with Federal regulation and State statute. In addition, the facility failed to maintain evidence the allegation was thoroughly investigated and the results reported as required. The findings were: Review of a grievance report dated 5/24/08 at 6:30 PM showed resident #6 reported s/he was missing $15. The resident identified the missing money as $6 in coins and $9 in bills. Written on the back of the grievance report was "Long wkend [weekend], found out on the 27th." Review of internal reports showed there was no investigation of this allegation. The following concerns with failure to thoroughly investigate and report this allegation were identified: a. The administrator was not informed of the allegation until 5/27/08, more than 60 hours after it occurred. b. During an interview on 6/12/08 at 11:55 PM, the administrator stated he interviewed the resident and "everyone on the shift." However, non-nursing employees, visitors, and other residents or family members were not questioned. c. During the aforementioned interview, the administrator confirmed he did not notify the police, complete a written report of the facility's investigation, or notify required officials of the results of his investigation. d. On 6/12/08 at 2:15 PM, the director of nurses stated the administrator informed her that he did not report the allegation of theft to the Department of Family Services. Review of "Title 35: Chapter 20 - Adult Protective	F 225		7/9/08

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F 225	Continued From page 2 Services 35-20-103" showed "(a) Any person or agency who knows or has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, exploited or abandoned or is committing self neglect shall report the information immediately to a law enforcement agency or the department."	F 225		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	F272 - Comprehensive assessments Resident #1, #2, #3, #4 and #5 were reviewed on 7/3/08 for comprehensive assessment by the IDT team, for causal and contributing factors identified in each RAP summary. Care plans and care cards updated for current interventions as appropriate for each resident. . IDT team have reviewed all incident and accidents in the last 3 months	7/9/08

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments related to falls for five (#1, #2, #3, #4, #5) of five sample residents at risk. In addition, comprehensive assessments were totally lacking for resident #4. The findings were: 1. Review of the current Resident Assessment Instrument (RAI) Minimum Data Set (MDS) assessments for residents #1, #2, #3, and #5 showed each resident required a comprehensive assessment for falls. Further review of the record showed all causative and contributing factors were not identified. Each Resident Assessment Protocol (RAP) summary documented the resident as at risk for falls due to consumption of a medication or medications and, in the cases of residents #1 and #2, because of having sustained a previous fall. Factors such as quadriplegia, amputation, spina bifida, Parkinson's, weakness, impaired vision, and impaired respiratory function were not addressed in the summaries. Interview with an MDS coordinator, employee #3, on 6/12/08 at 2:30 PM verified that all causative and contributing factors were not assessed. She also stated this was the way they were taught to do the assessments. 2. Medical record review showed resident #4 was frequently hospitalized and returned to the facility on Medicare. Each time, the appropriate Medicare MDS forms were completed, but comprehensive assessments were lacking. According to the 3/6/08 Medicare MDS, the	F 272	and identified residents with significant change. Causal and contributing factors identified in each RAP summary. Care plans and care cards have been updated for current interventions as appropriate for each resident. . DON or designee will audit MDSs and RAP summaries to ensure causal and contributing factors have been addressed in the RAP summary and Care plans and care cards have been updated. Audit to be done for all MDSs due in one month, and then 5 MDSs due each month for 3 months. Trending and tracking will be done on a weekly basis and taken to QA & A to be reviewed.	7/9/08

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F 272	Continued From page 4 resident did require a comprehensive assessment for falls. At 4:25 PM on 6/12/08, employee #3 reviewed the medical record and reported she checked the computer records. She stated an RAI assessment had not been completed since January 2007 (more than 17 months prior to survey date).	F 272		
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete quarterly assessments as required for one (#4) of four sample residents who needed that type of assessment. The findings were: Review of the Minimum Data Set (MDS) assessments for resident #4 showed the last quarterly assessment was dated 10/3/07. On 6/12/08 at 4:25 PM an MDS coordinator, employee #3, reviewed the assessments and confirmed no quarterly MDS assessment had been completed since that date.	F 276	F276 - Quarterly review assessment A comprehensive assessment completed on resident #4 on 6/17/08. Subsequent quarterly assessments have been scheduled quarterly. A "Tickler File" ran 6/30/08 to identify possible late or missing assessments. Education to be conducted for IDT team to ensure that all assessments scheduled will be completed and signed by RN in a timely manner. Computer generated "tickler" file will be ran weekly for review of late or missing assessments. File will be reviewed by, DON, MDS coordinator and RCMD. MDS assessment schedule will be reviewed at each IDT. Trending and tracking will be done on a weekly basis and taken to QA & A to be reviewed.	7/9/08