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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADON - Assistant Director of Nursing CAA - care area assessment CNA - Certified Nurse Aide DON - Director of Nursing IDT - Interdisciplinary Team LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set PRN - Pro re Nata (as needed) RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and medical record review, the facility failed to ensure 1 of 10 sample residents (#5) received care and services in a dignified manner. The findings were: Review of the medical record showed resident #5 was admitted to the facility on 3/26/14, blind, alert and oriented, and capable of independent ambulation with a cane. Review of the 4/2/14	F 241	**F 241 Dignity** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of the facility to promote care for residents in a manner and in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	6/25/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dennis R. Tofano — Administrator — 6/12/14

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.

RECEIVED
WY Dept of Health
JUN 12 2014
Healthcare Licensing and Surveys

OVC

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 241	Continued From page 1 admission MDS and CAA showed s/he required supervision with most activities of daily living due to blindness, and that being blind was frustrating to the resident. Review of the care plan, dated 3/26/14, showed blindness was identified as a problem, but specific approaches regarding the resident's dignity as it related to his/her blindness were not addressed. During an interview on 5/16/14 at 10:45 AM, the resident stated it was difficult for him/her to depart from the dining room after meals because the hallway outside the dining room was congested with residents in wheelchairs. The resident stated sometimes other residents became upset when s/he unknowingly touched them while attempting to leave the dining room. Observation on 5/15/14 at 11:28 AM revealed resident #5 sat at the dining room table with three other residents waiting to be served lunch. Continued observation revealed 2 of the 3 residents finished eating by 12:20 PM and departed. At 12:30 PM while resident #5 was still waiting to be served all of the other residents in the dining room were eating. At that time resident the resident expressed his/her frustration at waiting so long to be served and made the decision to leave the dining room without eating. The charge nurse intervened, encouraged the resident to remain, and the resident received lunch.	F 241	**Corrective Action** No immediate corrective action could be taken. Resident #5 was discharged on 05/21/2014 **Identification of Others** An observation audit of dining room will be completed by 6/16/2014 by DON/Designee to identify any additional residents who are not receiving timely assistance to and from dining room and are not being served meals timely with tablemates. Corrective action will be taken as needed for any identified concerns. **Systemic Changes:** Staff will be educated by Staff Development Coordinator or designee by 6/12/2014 on maintaining dignity by providing a safe environment for walking/ambulating residents to and from dining room. Staff will be educated on maintaining dignity by monitoring dining room that all residents to receive their meals timely upon arrival to dining room and tablemates are served at same time.	6/25/14
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	**Monitoring:** Random audits will be conducted by DON/designee for clutter free hall/path into and out of dining room and timely assistance to and from dining room and	

6/19/14 This POC agreed to with agreed to change between Denise Tofsrud, Administrator and Tony Madden, Surveyor with a POC of 6/25/14.

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 241	Continued from page 1 admission MDS and CAA showed s/he required supervision with most activities of daily living due to blindness, and that being blind was frustrating to the resident. Review of the care plan, dated 3/26/14, showed blindness was identified as a problem, but specific approaches regarding the resident's dignity as it related to his/her blindness were not addressed. During an interview on 5/16/14 at 10:45 AM, the resident stated it was difficult for him/her to depart from the dining room after meals because the hallway outside the dining room was congested with residents in wheelchairs. The resident stated sometimes other residents became upset when s/he unknowingly touched them while attempting to leave the dining room. Observation on 5/15/14 at 11:28 AM revealed resident #5 sat at the dining room table with three other residents waiting to be served lunch. Continued observation revealed 2 of the 3 residents finished eating by 12:20 PM and departed. At 12:30 PM while resident #5 was still waiting to be served all of the other residents in the dining room were eating. At that time resident the resident expressed his/her frustration at waiting so long to be served and made the decision to leave the dining room without eating. The charge nurse intervened, encouraged the resident to remain, and the resident received lunch.	F 241	timely serving of meals with tablemates served together 3 times a week x 4 weeks, then 2 times a week x 4 weeks, then 1 time per week x 4 weeks. The DON/Designee will track and trend the results of the dignity audits and report findings to the QAPI committee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		6/25/14

6/25/14

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

PRINTED: 06/02/2014
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 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 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) COMPLETION DATE
F 323	Continued From page 2 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to formulate or implement care-planned interventions to prevent falls or injuries for 6 of 11 sample residents (#10, #36, #77, #84, #93, #108) at risk for falls or injuries. The findings were: 1. Review of the 2/3/14 quarterly MDS assessment showed resident #84 was wheelchair dependent, had cognitive impairment, and urinary incontinence, and required extensive assistance with toileting and transfers. Review of the 2/14/14 care plan showed interventions for fall prevention included: remind resident to use call light, attach a chair alarm when up, provide scheduled toileting assistance, and observe for potential patterns of falls to identify possible causes. Further review revealed the resident did not consistently use the call light to call for assistance and frequently removed the chair alarm. Review of the medical record showed the resident fell on 1/18/14, 2/6/14, 4/8/14, and 4/18/14. Review of the interdisciplinary post fall reviews showed 3 of the 4 non-injury falls occurred when the resident attempted to go to the bathroom without staff assistance. The following concerns were identified: a. Observation on 5/15/14 at 11 AM revealed the resident was in the bathroom calling out for assistance because s/he had gotten out of the wheelchair, and was positioned between the wheelchair and bathroom commode. Continued	F 323	**F 323 Accidents** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of the facility to establish an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action** Resident #84- staff were immediately educated that mechanical lift not to be stored in resident's bathroom. Staff were educated that TAB's monitor to be attached to shirt instead of sweater. RCS's educated on timeliness and preparation to assist/toilet residents. Resident #93 pressure mat was reinstated to the bed and call light placed within reach on 5/16/2014, staff educated. Resident #77 Call light was placed within reach and staff educated on 5/16/2014. Resident #36 Call light was placed within reach and staff educated on 5/16/2014. Resident #10 pressure alarm mat reinstated to wheelchair. Resident #108 no corrective	6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 323	Continued From page 3 observation revealed the resident was unable to complete the transfer and grasped the safety bar and the mechanical lift to keep from falling. At the request of the surveyor, the staff intervened to prevent the resident from falling, and CNA #2 provided the toileting assistance the resident needed. During an interview on 5/15/15 at 11:05 AM, the CNA stated the chair alarm had not activated because the alarm had been attached to a sweater the resident removed before going into the bathroom. The CNA further stated the resident was confused and the mechanical lift should not have been in the bathroom. b. Observation on 5/15/14 at 6:05 PM revealed the resident sat in the wheelchair in his/her room. At that time the resident stated the CNA had gone to find a second CNA to assist with getting the resident to the bathroom. The resident also stated s/he was having a difficult time "holding it"... "it already started coming".. and s/he wanted to go to the bathroom without waiting for the CNA. Continued observation revealed CNA #3 brought a mechanical lift sling into the room and then departed after telling the resident to wait until a second CNA could be found. At 6:20 PM, CNA #3 and CNA #2 assisted the resident to the bathroom and noted the small amount of urine on the disposable brief. (Fifteen minutes after the resident requested assistance.) c. On 5/16/14 at 2:38 PM interview with the ADON, unit manager and DON revealed the IDT had not determined whether the current approaches were consistently implemented, nor had they re-evaluated them for effectiveness. 2. Review of the 3/3/14 quarterly MDS assessment showed resident #93 had diagnoses that included heart failure, diabetes mellitus, non-Alzheimer's dementia, chronic obstructive	F 323	action could be taken as resident expired 5/3/2014. **Identification of Others** All residents at risk for falls will be reviewed for proper interventions by Director of Nursing/Designee by 06/17/2014. Residents at risk of skin tears will be reviewed for need of skin protectors by Director of Nursing/Designee by06/17/2014 . **Systemic Changes** The Staff Development Coordinator will educate staff on 6/12/2014 on fall prevention, fall precautions, interventions, placement of TAB's monitor clips, call light placement and not storing mechanical lifts in occupied resident rooms or bathrooms. The interdisciplinary team will be educated by 06/12/2014 by Director of Nursing/Designee on post-accident investigation and review process including review of effectiveness of current interventions and review of consistent implementation of interventions and implementation of new interventions. **Monitoring:** An observation audit by DON/designee of proper call light placement, proper lift	6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 323	Continued From page 4 pulmonary disease and morbid obesity, and further showed the resident required the extensive assistance of two persons for bed mobility and transfers. Review of the resident's care plan for falls, most recently updated on 5/5/14, showed interventions intended to prevent falls included a pressure mat (alarm) to be applied to the resident's bed, and placing the resident's call light within reach. The following concerns were identified: a. Observation on 5/15/14 at 10:05 AM showed the resident was sleeping in bed. No pressure mat was applied to the bed, and the resident's call light was on the floor, out of the resident's reach. b. Observation of the resident's room on 5/16/14 at 9:10 AM again showed no pressure mat was applied to the bed. Interview with CNA #1 at that time revealed she was unaware the resident was supposed to have a pressure mat. c. Interview with the DON on 5/16/14 at 1:10 PM confirmed the resident was supposed to have a pressure mat, and had a pressure mat until a recent room change. She further confirmed resident call lights were supposed to be placed where residents could reach them. 3. Review of the 12/22/13 quarterly MDS assessment showed resident #77 had diagnoses that included glaucoma. Review of the fall risk evaluation dated 3/21/14 showed the resident was at high risk of falls due to intermittent confusion, medications, and predisposing conditions. Review of the resident's care plan for falls, most recently updated on 4/29/14, showed interventions intended to prevent falls included encouraging the resident to ask for assistance, and placing the resident's call light within reach. The following concerns were identified:	F 323	storage, proper monitor placement, and care planned fall interventions are in place will be conducted 3 times a week x 4 weeks, then 2 times a week x 4 weeks then 1 time a week x 4 weeks on varied shifts. An audit will be completed weekly for 3 months by Director of Nursing or designee after accidents to determine if care plan interventions were followed and if interventions were reviewed and updated post- accident, including interventions for skin tears. The Director of Nursing or designee will track and trend the results of the accident audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 323	Continued From page 5 a. Observation on 5/14/14 at 11:03 PM revealed the resident was sleeping in bed. The resident's call light was wedged in between the bed frame and the mattress. b. Observation on 5/15/14 at 10:27 AM revealed the resident was seated in the recliner in his/her room, sleeping. The call light remained wedged in between the bed frame and the mattress. During interview at that time, RN #1 confirmed the call light was supposed to be within the resident's reach, stating, "I don't know why that was there." c. Interview with the DON on 5/16/14 at 1:10 PM confirmed resident call lights were supposed to be placed where residents could reach them. 4. Review of the 2/14/14 quarterly MDS assessment showed resident #36 had diagnoses that included Alzheimer's disease, non-Alzheimer's dementia and heart failure. Review of the fall risk evaluation dated 2/14/14 showed the resident was at high risk for falls due to intermittent confusion, incontinence, medications and predisposing conditions. Review of the resident's care plan for falls, most recently updated on 3/31/14, showed interventions intended to prevent falls included encouraging the resident to ask for assistance, and placing the resident's call light within reach. The following concerns were identified: a. Observation on 5/14/14 at 11:03 PM revealed the resident was sleeping in bed. The resident's call light was hanging from the wall outlet, well out of the resident's reach. b. Observation on 5/15/14 at 10:20 AM revealed the resident was awake and lying in bed. The call light was still hanging from the wall outlet. At 10:25 AM, LPN #1 entered the room and spoke to the resident. The LPN left the room	F 323		6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 323	Continued From page 6 without placing the call light within the resident's reach. During interview at 10:30 AM, RN #1 was unable to explain why the resident's call light was hanging on the wall, and confirmed the call light was supposed to be within the resident's reach. RN #1 removed the call light from the wall, and attached it to the bedding next to the resident. c. Interview with the DON on 5/16/14 at 1:10 PM confirmed resident call lights were supposed to be placed where residents could reach them. 5. Review of the 1/2/14 quarterly MDS assessment showed resident #10 was wheelchair dependent, had cognitive impairment, and urinary incontinence, and required extensive assistance with activities of daily living. Review of the care plan showed interventions included: remind resident to use call light, place call light in reach, bed low, alarm unit on bed and attach when in recliner, mat on the floor and pressure pad in recliner, and scheduled voiding. Review of the 2/15/14 interdisciplinary fall review record showed the resident fell on 3/25/14, 4/8/14, 5/2/14, 5/9/14, and 5/20/14. This review also showed no serious injuries resulted from the falls. However, review of the care plan showed no additional interventions were implemented after 2/15/14 until 5/14/14. Review of the medical record showed staff implemented a pressure pad alarm for the wheelchair on 5/14/14. On 5/16/14 at 2:38 PM interview with the ADON, unit manager and DON confirmed there was a delay in evaluating an additional approach and stated they did not have an explanation for the delay. 6. Review of the 1/19/14 quarterly MDS assessment showed resident #108 was wheelchair dependent, had cognitive impairment, and required extensive assistance with activities	F 323		6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 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) COMPLETION DATE
F 323	Continued From page 7 of daily living. Review of the care plan showed staff identified fragile skin as a problem. Care plan interventions included monitoring for skin tears. Further review revealed no interventions for providing protective measures were identified or implemented. Review of the skin monitoring and assessment report showed the resident had the following skin tears: on 1/20/14 the right upper calf, on 2/23/14 the right forearm, on 4/7/14 the left lower leg, on 4/26/14 the left upper arm and on 4/27/14 the right elbow. According to the documentation staff applied a skin guard to protect the resident's legs in January 2014. However, review of the skin monitoring logs and nursing assessment showed no evidence the shin guard was evaluated for effectiveness, nor was there evidence that geri-sleeves were considered for evaluation. In an interview on 5/16/14 at 2:38 PM the ADON, unit manager and DON confirmed the lack of evidence regarding the shin guard effectiveness evaluation and all agreed the geri-sleeve should have been considered for evaluation by the IDT.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	**F328 TREATMENT/CARE FOR SPECIAL NEEDS** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law It is the practice of the facility to ensure that residents receive proper treatment and care for special services.	6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 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) COMPLETION DATE
F 328	Continued From page 8 This REQUIREMENT Is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to assess respiratory needs for 3 of 4 sample residents (#36,#77,#93) and 1 non-sample resident (#29) who required supplemental oxygen, and 1 non-sample resident (#29) who required the use of a BIPAP (biphasic positive airway pressure) machine. The findings were: 1. Review of the 3/3/14 quarterly MDS assessment showed resident #93 had diagnoses that included heart failure, non-Alzheimer's dementia, and chronic obstructive respiratory disease, experienced shortness of breath with exertion, and required the extensive assistance of two persons for bed mobility, transfers and dressing. Review of the resident's respiratory care plan showed interventions such as "Administer oxygen as ordered" and "Pulse oximetry as indicated." Review of the physician's order recapitulation for the month of May, 2014 showed the resident had an order with a start date of 11/20/13 for "...Titrate oxygen to maintain oxygen sat [saturation] =/> [equal to/greater than] 89%." The following concerns were identified: a. Observation on 5/15/14 at 12:13 PM revealed the resident was lying in bed. CNA #1 entered the room and asked the resident if s/he wanted to go to lunch. The resident was assisted out of bed and into his/her wheelchair. There was no oxygen tank on the wheelchair. The resident was pushed out of the room and down the hall toward the dining room. Pulse oximetry, performed by CNA #1 at 12:17 PM revealed the resident's oxygen saturation level at that time was 86%.	F 328	**Corrective Action** As of 05/16/2014 resident #93 order was corrected for O2 sats q shift and prn As of 06/10/2014 resident #29 Bipap was discontinued As of 5/16/2014 resident #77 Order transcribed to MAR for O2 at HS, O2 sats 2 times per week and prn As of 05/16/2014 resident #36. MAR updated to reflect O2 sats 2 times per week and prn **Identification of Others** By 6/17/14 ~~Before 5/16/2014~~ the Director of Nursing or designee will complete an audit of residents with respiratory needs to determine if oxygen and related orders are accurate on CPO's and MAR's. The audit will include review of documentation including oxygen saturations and oxygen administration per physician orders, review of BIPAP or CPAP orders for completeness and documentation of administration, and care plans for respiratory needs. For any concerns identified the Director of Nursing or designee will take corrective action as appropriate. The Director of Nursing/Designee will conduct a facility-wide observation audit to confirm residents with supplemental oxygen are administered in accordance	6/25/14

6/13/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 328	Continued From page 9 b. Observation on 5/16/14 at 9:10 AM revealed the resident was seated in his/her wheelchair in the facility dining room. There was no oxygen tank on the wheelchair. The resident left the dining room and self-propelled toward his/her room. The resident was only able to propel for a short distance, approximately 5-10 feet, without stopping to rest. c. Interview with the DON on 5/16/14 at 9:48 AM confirmed residents who had physician orders to titrate oxygen would have their oxygen managed according to oxygen saturations levels, which would be measured through pulse oximetry. She further confirmed these measurements would be recorded on the resident's MAR. However, review of the resident's MARs for the months of April and May, 2014 showed no pulse oximetry measurements were recorded. 2. Review of admission orders showed resident #29 was admitted to the facility on 5/12/14 with diagnoses that included obstructive sleep apnea. Review of physician orders showed an order dated 5/12/14 for "...Titrate oxygen to maintain oxygen sat [saturation] =/> [equal to or greater than] 89%" and an order dated 5/14/14 for "Apply BiPAP - settings at 16/5 two bleed in lines - intermittently and PRN if resident hypoxic." The following concerns were identified: a. Observation on 5/14/14 at 10:35 PM showed the resident was asleep in bed. On the nightstand next to the bed, a BiPAP machine was plugged in and periodically beeping. The resident was not wearing a face mask. b. Further review of the resident's medical record showed s/he did not have a respiratory care plan which may have indicated when the BiPAP machine should be used.	F 328	with physician orders. Corrective action will be taken as needed. **Systemic Changes** The Staff Development Coordinator/Designee will provide education to nursing staff by 06/17/2014 addressing the following of physician orders for respiratory services including obtaining oxygen saturations and titration of oxygen, oxygen administration of oxygen per orders, BIPAP and CPAP orders and respiratory / oxygen administration care plans. **Monitoring** The Director of Nursing/Designee will conduct random weekly audits of 50% of residents with supplemental oxygen or other respiratory orders for four (4) weeks and monthly audits for three (3) months to confirm physician orders addressing the administration of supplemental oxygen are followed. The audit will include checking respiratory care plans. Corrective action will be taken as needed for any identified concerns. The Director of Nursing will track and trend the results of the supplemental oxygen orders audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends	6/25/14

6/25/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 328	Continued From page 10 c. Interview with the DON on 5/16/14 at 9:48 AM confirmed residents who had physician orders to titrate oxygen would have their oxygen managed according to oxygen saturations levels, which would be measured through pulse oximetry. She further confirmed these measurements would be recorded on the resident's MAR. Review of the resident's MAR for May, 2014 showed no pulse oximetry measurements were recorded. d. Interview with the DON on 5/16/14 at 1:10 PM revealed the facility had not determined how they would know if the resident was hypoxic and needed to utilize the BIPAP machine while sleeping. 3. Review of the 3/11/14 quarterly MDS assessment showed resident #77 had diagnoses that included atrial fibrillation and anemia, and received oxygen therapy while a resident. Observation of the resident's room on 5/15/14 at 10:27 AM revealed an oxygen concentrator placed against the wall on the side of the nightstand which was farthest from the resident's bed. During interview with the resident at that time s/he acknowledged the oxygen concentrator and stated, "I haven't used that for the last two or three days." Review of the resident's respiratory care plan revealed interventions including "Administer oxygen as ordered" and "Pulse oximetry as indicated." The following concerns were identified: a. Review of admission orders dated 8/10/11 showed the resident had a physician order for "O2 [oxygen] at 2 L [liters] per N/C [nasal cannula] SAO2[a measurement of oxygen saturation] Q [every] shift SAO2 > [greater than] 88-92%." Review of the resident's MARs for March and April, 2014 revealed there was no	F 328	identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	6/25/14

6/25/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 328	Continued From page 11 order for supplemental oxygen, and there were no recorded oxygen saturation measurements. Further review of the medical record failed to reveal any order to discontinue supplemental oxygen. b. Interview with the medical records director on 5/16/14 at 9:35 AM revealed the resident was admitted to the facility with orders for supplemental oxygen, the oxygen had not been discontinued by the physician, and the orders for supplemental oxygen and oxygen saturation monitoring had "somehow dropped" from the physician's order recapitulation and from the resident's MARs. 4. Review of the 2/14/14 quarterly MDS assessment showed resident #36 had diagnoses that included heart failure and Alzheimer's disease. Review of the April, 2014 physician's order recapitulation showed the resident had an order dated 9/2/13 for "...Titrate oxygen to maintain Oxygen sat [saturation] =/> [equal to or greater than] 89%." a. Interview with the DON on 5/16/14 at 9:48 AM confirmed residents who had physician orders to titrate oxygen would have their oxygen managed according to oxygen saturations levels, which would be measured through pulse oximetry. She further confirmed these measurements would be recorded on the resident's MAR. b. Review of the resident's MARs for the months of April and May, 2014 showed no pulse oximetry measurements were recorded.	F 328		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	**F 441 Infection Control** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	6/25/14

6/25/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 441	Continued From page 12 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review	F 441	It is the practice of the facility to establish an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action** CNA#1 was immediately educated on 5/15/2014 on proper shower cleaning procedure. Quat cleaner was removed and replaced with the Clorox cleaner. All CNA's on duty were educated immediately on 5/14/2014 and 5/15/2014 on proper handling of contaminated linens. **Identification of Others** All residents are at risk from improper sanitation of shower chairs and improper linen handling. **Systemic Changes** Staff Development Coordinator will educate staff on 6/12/2014 on proper cleaning solution / technique / procedures for shower chair and surfaces .and proper handling of contaminated linen. Linen bin use in halls will be implemented 2 sets by 06/10/2014 and the remainder by 06/25/2014 for easier containment of soiled linen. 6/25/14	

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 9 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) COMPLETION DATE
F 441	Continued From page 13 of manufacturer's instructions the facility failed to effectively disinfect the shower chair between resident showers on 1 random observation, and failed to handle soiled laundry so as to prevent the spread of infection during 1 random observation. The findings were: Regarding shower chair disinfection: Observation of the 600 hall shower room on 5/15/14 at 11:05 AM revealed CNA #1 walked a resident back to his/her room after a shower. The CNA then returned to the shower room, gathered the trash and used a substance in a spray bottle to spray the shower chair. Immediately after spraying, the CNA turned on the hand held shower, and rinsed off the shower chair. During interview with the CNA at that time, she indicated the spray bottle that she used to spray the shower chair contained Quat Disinfectant Cleaner, and stated that Quat Disinfectant Cleaner had a ten minute wet time. She further confirmed she had not observed the ten- minute wet time, stating that instead she "scrubbed it down." Review of manufacturer's instructions for Quat Disinfectant Cleaner revealed "Treated surfaces should remain wet for 10 minutes." Interview with the infection preventionist on 5/16/14 at 2:50 PM revealed the facility had recently switched to Clorox Bleach Germicidal Cleaner, and the CNA should not have been using Quat Disinfectant Cleaner. The infection preventionist further confirmed that, since Quat Disinfectant Cleaner had been used, the CNA should have observed the ten-minute wet time. Regarding soiled laundry handling:	F 441	**Monitoring:** An audit by DON/designee of proper cleaning procedure of shower chairs will be conducted 3 times a week x 4 weeks, then 2 times a week x 4 weeks then 1 time a week x 4 weeks on varied shifts. Corrective action will be taken for identified concerns. A random observation audit for proper linen handling will be completed at varied times 3 times per week by the Director of Nursing or designee for 3 months. Corrective action will be taken for identified concerns. The Director of Nursing will track and trend the results of the linen handling and shower chair cleaning audits and report findings to the QAPI Committee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	6/25/14

6/19/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 441	Continued From page 14 Observation on 5/14/14 from 10:15 PM to 10:35 PM revealed there was a pile of dirty clothing against the wall on the floor on the 100 hall between rooms 107 and 108. During the observation there were no residents in the area and CNAs on duty went in and out of resident rooms and ignored the dirty clothing. Interview with the administrator and DON on 5/16/14 at 10:30 AM revealed this was an infection control concern and not an acceptable facility practice.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure effective pest cotrol measures were implemented. The findings were: Observation on 5/14/14 at 10:40 PM revealed pieces of meat, tomatoes, crumbs, dirt, and partially dried areas of spilled juice were on the floors of both dining rooms. In addition ants were observed crawling on the floor in both dining rooms. Interview with the administrator on 5/14/14 at 10:56 PM and again on 5/16/14 at 2:45 PM revealed the dining room floors should have been swept after the evening meal. He further stated he needed to make sure the pest control company sprayed the window sills in addition to the outside and inside areas they were scheduled	F 469	**F 469 Pest Control** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of the facility to establish an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action:** Immediate cleaning of the food on the floor was completed by staff. Eco Lab was notified on 5/14/14 for dining room to be treated for ants. 6/25/14	

6/25/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 469	Continued From page 15 to do.	F 469	**Identification of Others:** Dining area is at risk after meals for spillage and ants. The housekeeping supervisor will complete a facility wide audit by Maintenance Director or Designee to identify any additional pest control concerns. Corrective action will be taken as needed. **Systemic Changes** Administrator/designee will educate staff on environmental cleanliness of the dining area on 6/12/2014.the training will include prompt reporting if any ants are noted in facility. The dining areas will be cleaned and swept after meals by housekeeping/designee. Eco-Lab has been scheduled for monthly and as needed treatment for ants	

6/25/14

6/16/14

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

PRINTED: 06/02/2014
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 05/16/2014

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) COMPLETION DATE
F 469	Continued From page 15 to do.	F 469	**Monitoring:** An audit by Administrator or designee of proper cleaning of dining rooms and monitoring for ants will be conducted 3 times a week x 4 weeks, then 2 times a week x 4 weeks then 1 time a week x 4 weeks on varied shifts. The Administrator or designee will track and trend the results of the dining room cleaning audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	6/25/14

6/25/14