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Healthcare Licensing and Surveys

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

PRINTED: 09/04/2014
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 _____	R-C 08/15/2014

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	{F 000}	"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" This plan of correction is the facility's credible allegation of compliance.	
	The following common abbreviations are used throughout this document: ADON - Assistant Director of Nursing DoC - Date of Compliance DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Assessment PoC - Plan of Correction RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.			
{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, staff interview, and medical record review, the facility failed to ensure staff maintained the dignity of 1 of 14 sample residents (#11). In addition this deficient practice was evidence the facility was not in compliance with their PoC and proposed 6/24/14 DoC. The findings were: Review of the 6/14/14 comprehensive MDS showed resident #11 had cognitive impairment, understood others, was ambulatory with supervision, and did not have wandering or resistive to care behaviors.	{F 241}	**F241** 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. Corrective Action: Resident #11 was reviewed by IDT and the alarming device was removed and the plan of care updated. Identification of Others: An audit was conducted of residents with wander guards. System Measures: Residents identified as having a current wander guard were assessed to determine if the wander guard is appropriate. Residents with wander guards have had care plan updated in place. Residents will be assessed upon admission, quarterly, with significant change and as needed.	9/15/14

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

Donna Tofano — Administrator — 9/25/14

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.

9/26/14. PoC accepted. Administrator D. Tofano notified via telephone call @ 0845. J. VanDyke, RN

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POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

9/26/14

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{F 241}	Continued From page 1 Review of the nursing notes, dated 6/27/14, revealed the resident left his/her wheelchair inside the facility and was found standing in the parking lot. Review of the interdisciplinary post-fall review showed the resident was found outside the building sitting on the grass on 7/6/14. According to the documentation on 6/27/14 and 7/6/14 during both incidents the resident wore an alarm device that activated when s/he exited the facility, and s/he resisted when staff attempted to bring him/her back into the facility. Further review revealed the resident's behavior during both incidents was described as "combative". During an interview on 8/14/14 at 2:25 PM the DON stated both incidents occurred due to miscommunication. She stated the resident resisted because s/he was unable to make staff understand that s/he was waiting for friends to take him/her to church. The DON further stated the resident did not need the alarm device and staff needed to know that the resident was capable of going outside to wait for friends. At that time the DON acknowledged that if the reassessment of the resident's decision making skills had been done sooner, the alarm would have been removed and it might have prevented the second incident when staff tried to direct the resident back into the building unnecessarily. Periodic observations of the resident on 8/12/14, 8/13/14, 8/14/14, and 8/15/14 revealed staff had not removed the alarm device (more than six weeks after the second incident).	{F 241}	Staff will be in serviced on resident use of wander guards and need. Monitor: Resident changes will be monitored via business daily morning meeting and adjustments made as necessary, any adjustments, trends or patterns regarding this plan will be analyzed monthly during QAPI meeting by NHA/Designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	
{F 323} SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	{F 323}		9/15/14

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{F 323}	Continued From page 2 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure effective interventions were implemented to prevent falls for 3 of 7 sample residents (#7, #12, #13) identified at risk for falls. In addition, staff failed to provide timely medical and nursing care for 1 resident (#13) who had assessed changes in health status following multiple falls. This failure resulted in actual harm for 1 resident (#13) and was evidence of the facility's inability to sustain compliance with their PoC and proposed 6/24/14 DoC. The findings were: 1. Medical record review showed resident #13 was admitted to the facility on 3/17/14 with diagnoses which included dementia with behaviors, cerebral vascular accident, and osteoarthritis. Further review showed the resident had 16 falls which occurred on 3/20/14, 3/30/14, 4/3/14, 4/18/14, 5/7/14, 5/19/14, 5/21/14, 6/7/14, 6/18/14 twice, 6/23/14, 6/27/14, 7/2/14, 7/8/14, 7/11/14, and 7/14/14. The following concerns were identified: a. Review of Interdisciplinary Post Fall Reviews dated 4/4/14, 5/13/14, 5/21/14, 6/9/14, 6/21/14, 7/3/14, 7/9/14, and 7/11/14 showed one of the recommendations of the team that signed the reviews was to revise the care plan. However, review of the care plan showed the plan	{F 323}	**F323** 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 prevent accidents. Corrective Action: Resident #13 was discharged from facility. Resident #12 has been discharged from the facility. Resident # 7 has current fall interventions in place. Identification of Others: Facility audit was conducted to determine current individualized fall interventions. System Measures: Weekly rounds for fall interventions will be conducted by DON/Designee to ensure current interventions are in place weekly for 6 weeks then monthly for three. Staff was in serviced on fall interventions, investigation, implementation, reporting and validation. Facility van driver was educated by NHA/Designee regarding van safety and fall interventions and reporting concerns. Monitor: Accident and Incident reports will be monitored daily Monday through Friday during morning business meeting for patterns regarding this plan will be analyzed monthly during QAPI meeting by DON/Designee.	9/15/14

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{F 323}	Continued From page 3 concerning falls was initiated on 3/31/14 and was only reviewed and/or revised on 4/4/14, 7/11/14, and 7/22/14 (3 times for 16 falls). The facility failed to review and/or revise the care plan on 5/13/14, 5/21/14, 6/9/14, 6/21/14, and 7/3/14 as recommended, and failed to document a rationale for why the care plan was not revised. b. Review of nursing notes showed the following: On 5/10/14, "Resident ambulating about with walker with slow, steady gait. On 6/20/14, "Was ambulated to room..." On 6/21/14, "Able to move all extremities. Continues to have some difficulty ambulating." On 6/22/14, "Able to move all extremities." The following changes were documented after the 7/11/14 fall: On 7/11/14 at 6 PM, "Wheelchair for mobility." On 7/18/14, "Resident holding left leg and complaint of pain." On 7/25/14, "Resident complained of leg cramps, tenderness, weakness in bilat [both] lower extremities over the last couple of days (as reported by staff). Resident refusing to bear weight." On 7/29/14, "WFP-physician visit-1. Ankle brace/index on left leg if pt. able to cooperate. 2. X-ray left knee complete for leg pain. 3. X-ray pelvis for left leg pain. 4. x-ray left femur 2 views for leg pain...Norco [narcotic pain medication] 5/325 1/2 tab BID [twice a day]. On 8/4/14, "Return from appt. Progress note + left femoral neck fx [fracture]. MD called and discussed recommendations with family/RP [resident's physician?]-Resident to be NWB [no weight bearing] left leg. Surgery scheduled for Thursday. X-rays for tomorrow were canceled....Resident has not been bearing weight-Staff have been using the lift to transfer." c. Interview with the resident's POA on 8/14/14 at 7:45 PM revealed the POA's spouse visited the resident between 7/11/14 and 7/28/14 (date uncertain) and notified staff that the resident	{F 323}	The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	9/15/14

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(F 323)	Continued From page 4	(F 323)		

appeared in pain any time s/he was moved. The POA visited the resident between 7/11/14 and 7/28/14 after the POA's spouse visited, and notified staff the resident would not/could not bear weight on his/her legs and was in pain. The POA stated this was different for the resident. The POA stated he notified the MD after his visit and was told he could get a second opinion if he wished. The POA stated he then set-up the appointment that resulted in the resident's Orthopedic visit with x-rays, followed by "total hip surgery."

d. Interview with the DON on 8/15/14 at 10:30 AM confirmed the facility did not always update the care plan or provide a rationale as to why the facility failed to do so. She further confirmed the facility failed to obtain a specialist appointment for the resident concerning his/her change in ambulatory status after the 7/11/14 fall until after the resident's POA intervened and scheduled the Orthopedic visit with x-rays that resulted in finding the fracture. This finding resulted in the resident undergoing a left hip hemiarthroplasty on 8/7/14.

2. Review of the 7/14/14 nursing admission assessment showed resident #12 was admitted from the hospital after leg amputation surgery. This review also showed the resident was alert and oriented and required supervision with transfers. According to the medial record the facility van was used to transport the resident from the facility to the wound clinic for care of the amputation surgical wound. The following concerns were identified regarding unsafe practices during resident transport:

a. Interview with the resident on 8/14/14 at 12:20 PM revealed the following information: on 7/28/14 s/he was transported by the facility van from the facility to the wound clinic for care of

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(F 323)	Continued From page 5 his/her surgical wound. The van driver stopped to pick up another resident before taking resident #12 to the clinic. When the driver left the van to assist the other resident, resident #12 was left alone on the van with van door opened and motor running. The driver was "gone for about 45 minutes", It was hot, and the heat made the resident feel "awful". S/he then moved out of the wheelchair, supported his/her weight with one leg and grasped the seats and support poles to aide his/her departure from the van. S/he turned the ignition off and positioned himself/herself through the opened door on the steps of the bus. b. During an interview on 8/14/14 at 3:15 PM the van driver verified the incident occurred as described by resident #12, except the van driver was unsure of how long she had left the resident alone. During the interview the van driver also stated she now realized how unsafe it is to leave a resident unsupervised on a van with the engine running and the door opened for prolonged periods of time. c. Interview on 8/14/14 at 1:20 PM with the DON and administrator revealed they had not investigated the incident or implemented measures to prevent reoccurrence because they were not aware of the incident. 3. Review of the 6/17/14 quarterly MDS assessment showed resident #7 was wheelchair dependent, had cognitive impairment, required extensive assistance with toileting and transfers and had multiple non-injury falls. Review of the 6/17/14 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 fall to identify possible causes. Further review revealed the resident did	(F 323)		9/15/14

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{F 323}	Continued From page 6 not consistently use the call light or call for assistance and frequently removed the chair alarm. Observation on 8/13/14 from 1:50 PM to 2:25 PM revealed the resident sat in his/her room with the chair alarm detached. Continued observation revealed the chair alarm was not reattached until the ADON responded to the roommates call light at 2:25 PM. At that time the ADON stated the chair alarm should be attached at all times.	{F 323}	**F441** Infection Control, Prevent, Spread, Linens The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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.	{F 441}	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 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 resident contact for which hand washing is indicated by accepted professional practice. (C) Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	9/15/14

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{F 441}	Continued From page 7 (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 of policies and procedures, the facility failed to effectively disinfect the glucometer during observations of blood glucose testing for 3 of 4 residents (#4, #19, #20) observed receiving this test. This occurred since the proposed 6/24/14 DoC and PoC for deficient practices related to infection control. The findings were: 1. Interview on 8/14/14 at 4:40 PM with LPN #1 and review of the manufacture's instructions revealed the method for effectively disinfecting the glucometer required using a disinfecting wipe and ensuring a two minute contact time. The following concerns were identified regarding staff's failure to follow this standard for effectively disinfecting the glucometer: a. RN #1 was observed performing fingerstick blood glucose testing for residents on 8/12/14 from 8:52 PM to 9:10 PM. During the observation, the RN cleaned the glucometer with an alcohol wipe for 15 seconds after using it for resident #4 and before using it for resident #19. Continued observation revealed the RN used the glucometer for testing resident #19's blood	{F 441}	Corrective Action: Glucometers are being cleaned between resident uses properly including residents #4, 19 and 20 per policy. Identification of Others: Nurses were observed for proper cleaning of glucometers between resident use and education provided for any improper handling. System Measures: Nursing staff were educated regarding the proper cleaning procedure for glucometers. DON/Designee will conduct random weekly observations of nursing staff to validate proper cleaning of glucometer weekly for four weeks then monthly for three. Monitor: Glucometer use and cleaning will be monitored by audits for trends or patterns regarding this plan will be analyzed monthly during QAPI meeting by DON/Designee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	9/15/14

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{F 441}	Continued From page 8 glucose level then placed the machine in a zipped storage case without disinfecting it. b. RN #2 was observed performing fingerstick blood glucose testing for resident #20 on 8/12/14 at 9:15 PM. During the observation, the RN disinfected the glucometer after use using a disinfecting wipe for 5 seconds.	{F 441}		9/15/14

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535024	A. Building B. Wing	8/15/2014

Name of Facility	Street Address, City, State, Zip Code
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0328 Reg. # 483.25(k) LSC	06/25/2014	ID Prefix F0469 Reg. # 483.70(h)(4) LSC	06/25/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/16/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO