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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535024	A. Building B. Wing	10/1/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 10/01/2014	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 10/01/2014	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By B 10/28/14	Date:	Signature of Surveyor: Jami VanDyke	Date: 10/17/14.
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

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 10/01/2014

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}		
{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. (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	{F 441}	**Preparation and/or execution of the response and plan of correction do not constitute admission of 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 the provisions of federal and state law require it.**	

RECEIVED
WY Dept of Health
OCT 24 2014
Healthcare Licensing and Survey

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DL Stacks	Senior Administrator	10-23-14

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.

10/27/14 POC accepted. DOC 10/24/14. Administrator Dan Stacks is notified by telephone at 4:05pm. J. VanDyke, RN

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{F 441}	Continued From page 1 infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policy the facility failed to ensure preventative infection control measures were maintained during 1 of 2 observed wound dressing changes (#105). In addition, this deficient practice was evidence the facility was not in compliance with their plan of correction and proposed 9/15/14 date of compliance. The findings were: Review of the medical record showed resident #105 was admitted to the facility on 4/24/12 with diagnoses including a left below the knee amputation and paralysis. Review further revealed the resident had a history of wound infections with methicillin resistant staphylococcus aureus (MRSA). Review of the medical record additionally showed the resident had open wounds on the left stump and right heel and lower posterior leg that required daily dressing changes. The following concerns were identified: a. Observation of a wound dressing change on 10/1/14 from 10:05 AM through 11 AM with the RN (registered nurse) wound care nurse revealed the following: The RN did not cleanse her hands prior to applying gloves and removed the old dressing from the resident's left stump. The old dressing was soiled with bloody drainage. Wearing the same gloves the RN touched the wound cleanser spray bottle, cleaned the open wound bed in a back and forth motion, and applied a clean dressing. She continued wearing the same gloves and reached into clean	{F 441}	F-441 **Corrective Action** Resident #105's wound was cleansed and dressing was changed in accordance with standard nursing practice. RN#1 was educated on October 5, 2014 addressing the protocols for skin management, wound care assessment, dressing changes, prep for dressing changes, and infection control practices.	

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{F 441}	Continued From page 2 packages for gauze and dressing supplies. She also used the bandage scissors from her uniform pocket to trim the dressings. The scissors were not cleaned prior to trimming the dressings. The RN redressed the wound on the left stump, and used the scissors to cut off the saturated old dressings on the resident's right lower leg. She then removed the dressing, which was packed into the wound and noted to have creamy yellow drainage and blood on it. She cleaned the wound with wound cleanser using a back and forth motion, and touched the wound cleanser bottle again with the same soiled gloves. She opened the door to let the resident's roommate exit, touched the foot board of the resident's bed, opened the resident's bedside table drawer to obtain a tube of ointment and applied the ointment to dry skin on the resident's right lower leg, all while wearing the same soiled gloves. After completing the above tasks she removed the gloves and applied a clean pair however, she did not perform hand hygiene between the glove changes. She completed the following tasks while wearing the newly applied pair of gloves: repacked the wound on the right lower leg with dressings, covered the wound, removed a marker from her uniform pocket and wrote the date on the dressings. She then carried the bandage scissors out into the hall, laid them on top of the cart and cleaned them. During an interview at the time of the observation the RN stated she usually "changed gloves twice during a dressing change," and was unaware of the facility's policy. b. Review of facility policy entitled, "Wound Assessment Objective: To perform a wound assessment according to the standard of care" dated 2014 instructed staff to, "gather necessary supplies, perform hand hygiene, put on gloves," and after the dressing change, "remove gloves	{F 441}	**Identification of Others** The Director of Nursing and/or Designee conducted weekly observations of wound care dressing changes to confirm acceptable nursing and infection control standards of practice are followed. Any identified areas of concern were corrected immediately. **Systemic Changes** The Staff Development Coordinator and/or Designee will conduct education to licensed nurses addressing wound assessments, dressing changes, and infection control practices on or before the date of compliance. The Director of Nursing and/or Designee will conduct weekly observations of wound care dressing changes for four weeks to confirm acceptable nursing and infection control standards of practice are followed.	

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{F 441}	Continued From page 3 and perform hand hygiene." Interview with the division director of clinical services on 10/1/14 at 1:20 PM revealed the facility utilized the Lippincott Nursing Manual for wound dressing change instruction and guidance. The interview verified staff should cleanse hands prior to applying gloves and should change gloves between old and new dressings, and wound sites as needed.	{F 441}	**Monitoring** The Director of Nursing and/or Designee will bring the results of the audits/observations to the monthly QAPI Committee for 3 months for review and recommendations. Date of compliance is October 24, 2014.	