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

PRINTED: 12/26/2014
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 12/11/2014

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the resident's guardian of a change in condition for 1 of 5	F 157	**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.** F-157 **Corrective Action** Resident #2 has been discharged from the facility. **Identification of Others** The Social Services Manager and/or Designee will conduct a facility-wide audit of all resident face sheets to confirm that correct contact information is reflected for the resident's legal representative, interested family member, and physician. All face sheets found to have discrepancies will be updated to reflect the correct contact information.	

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

Daniel G. Stackis — Senior Administrator — 12-31-14

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.

1/16/15 @ 1:30pm POC accepted via telephone call with Administrator Dan Stackis. — PPrine

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POPLAR LIVING CENTER	4300 S POPLAR CASPER, WY 82601

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F 157	Continued From page 1 sample residents (#2) who experienced a significant change in condition. The findings were: Review of the nursing notes showed resident #2 was admitted to the facility on 5/6/14 and experienced a significant change in condition in October 2014. Review of the October 2014 nursing notes revealed staff noted the resident was unresponsive on 10/17/14 at 9:15 PM and applied oxygen, repositioning and close monitoring. Further review revealed the resident responded for a brief period of time then again became unresponsive. Review of the same nurse's notes showed the resident's condition was reported to the physician at 11:30 PM, but no attempt was made to notify the guardian. During an interview on 12/11/14 at 1:45 PM the administrator confirmed the resident's guardian was not notified when the resident's condition changed; and staff did call the guardian when the resident expired later that night. He further stated updated guardianship information had not been added to the medical record face sheet.	F 157	**Systemic Changes** The Social Services Manager and/or Designee will confirm the accuracy of contact information for the resident's legal representative, interested family member, and physician at time of admission and during care conference meetings. PP **Monitoring** The Social Services Manager 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 January 25, 2015.	