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

PRINTED: 03/18/2015
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 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

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F 000	INITIAL COMMENTS This survey was conducted in conjunction with the revisits to the December 11, 2014 and January 6, 2015 complaint surveys. In addition, seven new complaints were investigated. These complaints were WY00001977, WY00001985, WY00001989, WY00001990, WY00001993, WY00001995 and WY00001997. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse ICP- Infection Control Practitioner PPE- Personal Protection Equipment Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, review of grievance investigations, and policy and procedure review, the facility failed to ensure grievance investigation results were shared with the individual who filed a grievance for 3 of 9	F 166	**F-166 RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** 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	

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

Admin 3/27/15

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.

DVW

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F 166	Continued From page 1 grievance investigations reviewed. The findings were: 1. Review of the facility grievance form called "Concern Form" showed the form had areas that included "Would you like to personally meet with someone about this concern?" and "Is the individual who raised concern satisfied with the resolution." Review of the facility policy and procedure titled, "Facility Grievance Guidelines" revised December 2006 included, "Notify the resident or family of the resolution. Respond to the resident and family within three days, even if the issue is not completely resolved." 2. Review of the 12/29/14 quarterly MDS assessment for resident #3 showed a brief interview of mental status (BIMS) score of "3" indicating severe cognitive impairment. The following concerns were identified: a. Interview with a family member of resident #3 on 3/3/15 at 12:05 PM showed s/he had filed grievances with the facility on multiple occasions, but often did not receive a response from the facility. b. Review of 6 grievance investigations in regard to resident #3 showed the area that stated, "Is the individual who raised concern satisfied with the resolution" was left blank on 3 of the 6 grievance forms (1/22/15, 1/29/15, 1/31/15). In addition, for all 6 grievance forms the family member marked "yes" for "Would you like to personally meet with someone about this concern?" c. Interview with the DON on 3/3/15 at 3:35 PM confirmed the facility failed to get back with the family member of resident #3 for some of those grievances.	F 166	It is the practice of the facility to ensure that a resident has the right to prompt efforts by the facility to resolve grievances the resident may have. **Corrective Action** Resident #3's family has been notified of the grievance resolutions. **Identification of Others** An audit of the Facility Concern Forms from 1/1/2015 to present has been completed and all families who had not been notified of the Concern Resolution have been contacted. **Systems Change** Facility management staff had been educated on the Facility Grievance Guidelines by the Administrator. **Monitoring** The Customer Services Director (CSD) or designee will monitor the Concern Forms received for compliance including timely family/resident notification of the resolution per the Facility	

3/31/15 @ 8:25 spoke to Tony Jarvis, Administrator. He agreed to change DOC date on F-166 & remove waiver request.

3/31/15 @ 2:00 PM this POC with agreed to changes accepted between Tony Jarvis, Administrator and Tony Madden, Surveyor.

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F 225 F 225 SS=D	Continued From page 2 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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.	F 225 F 225	Grievance Guidelines weekly for 90 days. Concern Forms that have not had family/resident notification of resolution will be contacted by the CSD and corrective action taken if necessary. The CSD will present a report of Concern Form compliance to the QAPI monthly meeting for review and corrective actions taken. The QAPI Committee will evaluate effectiveness of interventions and reassess the need for continued monitoring based on compliance. **F-225: Investigate/Report Allegations/individuals** It is the practice of the facility to 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.	4/2/15

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F 225	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, medical record review, and staff interview, the facility failed to ensure 1 of 3 allegations of resident abuse (#1) reported to the state survey and certification agency was thoroughly investigated within five working days as required. The findings were: Review of the 12/18/14 quarterly MDS assessment showed resident #1 had arthritis, schizophrenia, and cognitive impairment. Review of the care plan, revised on 2/24/15, showed s/he required extensive assistance with a sit-to-stand mechanical lift for transfers, was at risk for increased bleeding/bruising due to use of anticoagulant therapy, and had potential for skin impairment related to thin, fragile skin. Review of the 1/13/15 nursing quarterly evaluation showed the resident was verbally and physically abusive to staff and combative. According to the 1/31/15 nursing notes staff noted a large 3 inch x 4 inch purple bruise on the back of the left hand. Review of the facility investigation of the bruises on resident #1's hand showed it was reported to the state agency on 2/3/15. This review also showed the resident had short-term memory problems and described 2 staff who "hurt" him/her during a transfer on 1/31/15. Review of a second facility investigation regarding the bruises on the resident's hand showed this incident was reported to the state agency on 2/4/15. Further review showed the resident did not reference any wrong-doing by the staff and reported the bruises occurred on 1/26/15 when s/he grabbed the bar on the mechanical lift. Interview with the senior	F 225	**Corrective Actions** Interviews with staff who work with the mechanical lift including resident #1 were conducted regarding the potential for the mechanical lift to cause bruising to the resident's hand. The Administrator and DON monitored the use of the Mechanical Lift on resident #1 to examine the potential for bruising. The results have been reported to the Office of Healthcare Licensure and Survey. **Identification of Others** An audit of Investigations of Abuse Allegations had been completed by the Administrator for thoroughness of the investigations to include adequate interviews of staff and residents, safety of any equipment involved, and completion of the investigation within 5 working days. No corrective actions were necessary. **Systems Change** The management staff that has the potential to conduct investigations involving abuse including injury of unknown origin had been educated on the CMS investigation requirements per F-225 by the Administrator.	

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F 225	Continued From page 4 administrator on 3/3/15 at 4:30 PM revealed the two investigations were the same incident. He stated it was reported twice and investigated twice because the resident reported different incidents caused the same bruises. Review of the investigation summary showed the investigation was completed on 2/3/15. The following concerns were noted: a. The two staff who transferred the resident on 1/31/15 were interviewed; but efforts to gather additional information, including interviews with other staff, were lacking. b. The investigation failed to show any investigation of the mechanical lift, or any other circumstances surrounding the resident's bruise. c. Two staff who were on duty on 1/26/15 were interviewed regarding the reported 1/26/15 events. Again, additional staff were not interviewed. d. Resident #1 was the only resident interviewed during the investigations. e. In an interview on 3/3/15 at 11 AM, the administrator verified both investigations were missing some of the elements of a thorough investigation.	F 225	**Monitoring** The Administrator will review future Investigations regarding Abuse and/or injury of unknown origin for compliance to CMS F-225 including thoroughness of the investigation and timely reporting within 5 working days. Non-compliant investigations will be corrected immediately and the results will be reported at the QAPI monthly meeting for review and corrective actions if needed until resolved.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	**F-309: Provide Care and Service for Highest Well Being** The facility strives to ensure that each resident receives and is provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	4/1/15

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F 309	Continued From page 5 by: Based on resident and staff interview, observation, medical record review, standards of nursing practice, and facility policy review, the facility lacked evidence nursing staff provided the necessary assessments and monitoring for 2 of 3 residents on the secure dementia unit (#11, #12) who had signs and symptoms of gastrointestinal illness. The findings were: 1. Review of the 2/9/15 quarterly MDS assessment showed resident #11 had moderate cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 with personal hygiene. Observation on 3/2/15 at 1 PM showed the resident resided in the secure dementia unit. Interview with CNA #2 on 3/2/15 at 1:02 PM revealed this resident had been "sick since yesterday" (3/1/15). Interview with the resident on 3/2/15 at 6:05 PM revealed s/he "had not felt well and had diarrhea all day". Review of the 24 hour nursing report dated 3/2/15 showed the resident had "loose stool [after] lunch. will Hold Senna @ HS [at bedtime]. " The following concerns were identified: a. Review of the nursing notes showed no evidence an assessment of the resident was performed until 3/3/15 (notes timed at 3 PM), 2 days after the start of signs and symptoms. These notes showed the resident no longer had signs and symptoms of nausea, vomiting, or diarrhea. b. Interview with the DON on 3/4/15 at 10:10 AM revealed nurses did not document assessments in the nursing notes; they documented them on SBAR forms. However, review of the SBAR (Situation Background Assessment Request) form used to document	F 309	**Corrective Action** An SBAR was completed which included nurses evaluation, physician and family notification and care plan was written for resident #11 on 3/3/15 to address gastrointestinal illness. The care plan included condition requiring precautions, type of infection, prevention precautions. The symptoms were resolved on 2/24/15. An SBAR was completed which included nurses evaluation, physician and family notification and care plan was written for resident #12 on 3/3/15 to address gastrointestinal illness. The care plan included condition requiring precautions, type of infection, prevention precautions. The symptoms were resolved on 3/4/15. **Identification of Others** 24 hour reports were reviewed by the SDC to determine residents that have symptoms of gastrointestinal illness. The SDC completed SBAR's which included evaluation, physician and family notifications and updated care plans for those identified as needed.	

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F 309	Continued From page 6 assessments in change of condition showed it was also dated 3/3/15, 2 days after signs and symptoms were identified. 2. Review of the 2/24/15 quarterly MDS assessment showed resident #12 had severe cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 with personal hygiene. Review of the February 2015 recapitulation of physician orders showed the resident had diagnoses including dementia and resided in the secure dementia unit. On 3/2/15 at 12:50 PM the resident stated s/he was "wet". Interview with CNA #2 at that time revealed the "resident probably does [did] need changed because [s/he's] been having diarrhea since yesterday" (3/1/15). The following concerns were identified: a. Review of the 24 hour nursing reports for each day from 2/23/15 through 3/3/15 showed no evidence the resident's signs and symptoms, including diarrhea, were identified by nursing staff. b. Review of the nursing notes showed no evidence an assessment of the resident was performed. Further review of the nursing notes showed the last entry was dated 2/24/15 at 1 AM. Review of the vitals signs flow sheet showed the last set of vital signs recorded were on 2/20/15. c. Interview with the DON on 3/4/15 at 10:10 AM revealed nurses did not document assessments in the nursing notes; they documented them on SBAR forms. However, review of the SBAR (Situation Background Assessment Request) form used to document assessments in change of condition showed it was also dated 3/3/15, 2 days after signs and symptoms were identified.	F 309	**Systemic Changes** The Director of Nursing or designee will educate nurses on evaluating change of condition, documenting in medical record, documentation on 24 hour report, physician and family notification, developing care plans for those with infections. The 24 hour report, new telephone orders and new physician orders will be reviewed at morning interdisciplinary team meeting by Director of Nursing or designee. Documentation of nurse's evaluation, notifications and care plans will be checked at meeting to determine if a change of condition, including infections is addressed. **Monitoring** A random audit of 10 residents with change of condition will be completed weekly by Director of Nursing or designee for 30 days and then monthly for 2 months. The audit will include documentation of evaluation, notifications and care plan. Corrective actions will be taken as needed based on findings.	

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F 309	Continued From page 7 3. According to "Nursing Interventions & Clinical Skills", 5th Edition, 2012, by Perry, Potter, and Elkin, page 113, "Nurses perform systematic assessments on a regular basis in nearly every health care setting...In nursing homes..when a patient's health status changes". Review of the facility's policy on "Change of Condition", revised June 2008, showed the change of condition form should be used to assess and document changes in condition....provide clear comprehensive documentation."	F 309	The Director of Nursing or designee will track and trend the results of the change of condition 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.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to provide appropriate and timely toileting to restore as much normal bladder function as possible for 1 of 4 sample residents (#11) with incontinence. The findings were: Review of the quarterly MDS assessment dated 2/9/15 showed resident #11 had moderate cognitive impairment, was frequently incontinent	F 315	**F-315: NO CATHETER, PREVENT UTI, RESTORE BLADDER** It is the practice of the facility to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **Corrective Action** A new bladder evaluation will be completed for resident #11 by Director of Nursing or designee. After completion of the bladder evaluation the care plan for incontinence will be reviewed and updated as needed. Resident #11's	

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F 315	Continued From page 8 of bowel and bladder, and required extensive assistance of 2 with toileting and personal hygiene. Observation on 3/2/15 at 1:35 PM showed the resident resided in the secure dementia unit. Observation on 3/2/15 from 1:35 PM through 6:05 PM showed the resident was in bed. Observation at 1:52 PM showed CNA #2 entered the resident's room but provided no personal care. Interview with the resident at 6:05 PM revealed s/he had been sick with diarrhea all day. The resident asked to have his/her shirt changed because it was wet and s/he needed help. The CNA (#2), who was in the hallway at the time, was informed of the resident's request for assistance. Interview with the CNA at the time revealed the resident had been in bed all day with diarrhea and she immediately went in to change the resident's shirt. While changing the shirt the bed was observed to have a large, approximately 18 inch by 20 inch, area where urine had soaked through the resident's slacks and incontinence brief onto the sheet. The CNA changed the bedding. Review of the 11/17/14 care plan showed the resident should be toileted before and after meals, upon waking, at bedtime and as needed. Continuous observation from 1:52 PM to 6:05 PM showed the resident was not toileted or offered toileting for 4 hours and 13 minutes.	F 315	task list will be reviewed and updated as needed to reflect incontinence management interventions. Education will be completed with nursing staff that routinely provide care to resident # 11 on incontinence management interventions per care plan. **Identification of Others** The Director of Nursing or designee will identify residents on the secure dementia unit who are incontinent of bladder. The incontinence care plans for those identified will be reviewed and updated as needed. Task sheets will be reviewed for incontinence interventions and updated as needed. **Systemic Changes** The Staff Development Coordinator or designee will educate the nursing staff on incontinence management by 4/1. The education will include providing care in a timely manner in accordance with the care plan. **Monitoring** The Director of Nursing or designee will audit 5 care plan task lists for incontinence interventions	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353		

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F 353	Continued From page 9 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, family, resident and staff interview, staffing schedules and assignment sheets, and the resident census report, the facility failed to consistently ensure 5 of 5 nursing units were sufficiently staffed to meet the needs of residents. The findings were: 1. Review of the quarterly MDS assessment dated 2/9/15 showed resident #11 had moderate cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 with toileting and personal hygiene. Observation on 3/2/15 at 1:35 PM showed the resident resided in the secure dementia unit. Observation on 3/2/15 from 1:35 PM through 6:05 PM showed the resident was in bed. Observation at 1:52 PM showed CNA #2 entered the resident's room but provided no personal care. Interview with the resident at 6:05 PM revealed s/he had been sick with diarrhea all day. The resident asked to have his/her shirt	F 353	per care plan 3 times per week for 30 days and then weekly for 2 months. Corrective action will be taken as appropriate for Concerns identified. The Director of Nursing will track and trend the results of the incontinence 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. **F-353: SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLAN** The facility strives to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, psychosocial well-being of each resident, as determined by resident assessment and individual plan of care.	4/3/15

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F 353	Continued From page 10 changed because it was wet and s/he needed help. The CNA (#2), who was in the hallway at the time, was informed of the resident's request for assistance. Interview with the CNA at the time revealed the resident had been in bed all day with diarrhea and she immediately went in to change the resident's shirt. While changing the shirt the bed was observed to have a large, approximately 18 inches by 20 inches, area where urine had soaked through the resident's slacks and incontinence brief onto the sheet. The CNA changed the bedding. Review of the 11/17/14 care plan showed the resident should be toileted before and after meals, upon waking, at bedtime and as needed. Continuous observation from 1:52 PM to 6:05 PM showed the resident was not toileted or offered toileting for 4 hours and 13 minutes. 2. Interview with the DON on 3/4/15 at 10:10 AM, and verified by the administrator in an interview on 3/17/15 at 4 PM, revealed the routine shifts were 7 AM to 7 PM and 7 PM to 7 AM for nursing staff. For CNAs the shift hours were 6 AM to 6 PM and 6 PM to 6 AM with a few 4 and 8 hour shifts for staff who were unable to work the 12 hour shifts. 3. Based on review of the facility's census, there were 103 residents in-house on 2/24/15. Review of the staff time sheets for 2/24/15 provided by the facility on 3/16/15 showed during the night shift there were 3 RNs in the building to pass medications, provide treatments, and perform assessments as needed. An additional RN who worked the day shift stayed over into the night shift until 9:10 PM. There were 2 CNAs to care for 103 residents, 20 of whom were in a separate locked dementia unit. There was 1 CNA who	F 353	**Corrective Actions** A new bladder evaluation will be completed for resident #11 by 3/21/15 by Director of Nursing or designee. After completion of the bladder evaluation the care plan for incontinence will be reviewed and updated as needed. Resident #11's task list will be reviewed and updated as needed to reflect incontinence management interventions. Education will be completed with nursing staff that routinely provide care to resident # 11 on incontinence management interventions per care plan. **Identification of others** The Administrator and DON reviewed nursing staff schedules beginning on 3/19/15 through 4/30/2015 for sufficient nursing staff to provide nursing and related cares to the residents in accordance with their care plans. **Systemic Changes** The Staffing Coordinator or designee will contact available staff to make arrangements to provide sufficient nursing staff on days where necessary.	

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F 353	Continued From page 11 worked the day shift who did not leave her shift until 6:41 PM (41 minutes into the night shift). Finally, there were 2 RAs (resident assistants) who also worked from 6 PM to 11 PM and 1 RA who worked from 6 PM to 6 AM. However, review of the facility job description for an RA showed an RA was not qualified to provide personal care for residents. Their duties included keeping resident rooms neat and orderly, making beds, filling water pitchers, pushing wheelchairs, and answering call lights to let a resident know the RA would locate a CNA or nurse to assist him or her. The ratio of CNAs to residents was 1 to 51 during the night shift. 4. Based on review of the facility's census, there were 102 residents in-house on 2/25/15. Review of the staff time sheets for 2/25/15 provided by the facility on 3/16/15 showed during the night shift there was 1 RN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 7 AM. An additional RN who worked the day shift stayed over into the night shift until 9 PM. There was 1 CNA who worked the entire night shift to care for 102 residents, 20 of whom were in a separate locked dementia unit. An additional CNA worked from 10 PM to midnight. One CNA from the day shift worked until 6:30 PM, an extra 30 minutes. Finally, there was 1 RA who worked from 6 PM to 6 AM and 2 RAs who worked from 6 PM to 10:30 PM. One RA worked from 1 PM to 10 PM as well (4 hours into the night shift). Again, RAs were not qualified to provide personal care for residents. The ratio of CNAs to residents on the night shift was 1 to 102. The ratio of RNs to residents during the night shift was 1 to 102. 5. Based on review of the facility's census, there	F 353	The Administrator, DON, and Staffing Coordinator will review staffing levels 3 to 5 times per week to discuss any actions needed to provide sufficient nursing staff based on current census and care plan needs. The Administrator, DON and Staffing Coordinator will conduct 1 to 2 staffing calls with Corporate Level Managers to discuss employee retention, recruitment, and staffing levels. **Monitoring** The Director of Nursing or designee will audit 5 resident's care plan task lists 3 times per week for completeness (to include a minimum of 1 in the Secured Care Unit) to gauge sufficient staffing to provide nursing and other cares were completed per the resident's Care Plan for two weeks then 3 resident's care plan task lists (1 in the SCU) per week after that. The Customer Service Director or designee will conduct random interviews with interview able residents weekly for 4 weeks and then monthly for 2 months to find	

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F 353	Continued From page 12 were 104 residents in-house on 2/26/15. Review of the staff time sheets for 2/26/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 7 AM. There were 2 day shift RNs who worked over into the night shift; one until 9 PM and one until 7:30 PM. Continued review showed only 1 CNA worked the night shift from 6 PM to 7 AM to provide personal care for 104 residents, 20 of whom were in a locked dementia unit. One day shift CNA stayed until 6:30 PM and another CNA worked from 4:30 PM to 1 AM. One RA worked the entire night shift, one worked from 1 PM to 9:15 PM, and one worked from 6 PM to 7 PM. The ratio of CNAs to residents was 1 to 104 during most of the night shift from 1 AM to 6 AM. 6. Based on review of the facility's census, there were 104 residents in-house on 2/27/15. Review of the staff time sheets for 2/27/15 provided by the facility on 3/16/15 showed during the night shift there was 1 RN and 1 LPN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 7 AM. There were 3 CNAs on the night shift to care for 104 residents, 20 of whom resided in a locked dementia unit. In addition, one CNA worked from 5:30 PM to 1 AM, one from 6 PM to 10 PM, and one who worked until 7 PM. One RA worked from 1:45 PM to 8:41 PM. The ratio of CNAs to residents was 1 CNA to 34 residents after 1 AM. 7. Based on review of the facility's census, there were 103 residents in-house on 2/28/15. Review of the staff time sheets for 2/28/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs and 1 LPN in the building	F 353	out if their needs are being met in a timely manner. The results of the audits will be presented to the QAPI monthly meeting for review and corrective actions where necessary.	

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F 353	Continued From page 13 to pass medications, provide treatments, and perform assessments as needed from 7 PM to 8 AM. In addition, 1 day shift RN worked until 7:30 PM, 30 minutes beyond the end of the shift. There were 4 CNAs who worked the night shift for a ratio of 1 CNA to 26 residents. Two day shift CNAs worked over until 7 PM. No RAs worked during that night shift. 8. Based on review of the facility's census, there were 101 residents in-house on 3/1/15. Review of the staff time sheets for 3/1/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs and 1 LPN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 8 AM. In addition, 1 day shift RN worked 1 hour and 12 minutes beyond her shift and another worked an additional 2 hours into the night shift. There were 4 CNAs who worked the night shift for a ratio of 1 CNA to 26 residents. One CNA worked from 5 PM to 10:44 PM, one worked from 10 PM to 7 AM and there was 1 RA who worked from 6 PM to 6 AM. 9. Interview with 2 CNAs, #1 and #7 on 3/1/15 at 10 PM revealed there was almost always only 1 CNA for the night shift in the secure unit and 1 for the remainder of the halls. Both stated staffing had been and continued to be a "huge" issue. 10. Interview with a family member on 3/2/15 at 12:30 PM revealed the facility was short staffed. She said "I think they need more help." The family member verified there was only 1 CNA in the secure unit and 1 CNA on the halls outside the secure unit on the night shift; that was when incontinence care was not provided in a timely manner. She said the CNAs worked very hard	F 353		

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F 353	Continued From page 14 and provided the best care possible based on the number of staff available. 11. On 3/1/15 from 10:30 PM until 10:45 PM, CNA #3, CNA #6, CNA #4 and LPN #1 were interviewed individually regarding staffing. All stated there was insufficient staff on the second 12 hour shift and the lack of staff resulted in delayed response to call lights, delayed meal service, lack of monitoring for falls and the inability to provide toileting assistance timely. One CNA stated the supervisors and administrative staff came in or remained on duty to help at times, but not every time. The interview with the LPN revealed the licensed nurses had to postpone passing medications and assist the CNAs with resident care when there was insufficient staff on duty. The staff schedule for 2/24/15 to 3/1/15 was reviewed with the DON on 3/3/15 at 6:55 PM. At that time the DON stated staffing with CNAs continued to be a challenge, but the administrative staff were always available to work when there was insufficient staff. The surveyors requested evidence the administrative staff provided assistance on the second shift from 2/24/15 to 3/1/15. The facility provided the time sheets for staff, including administrative, on 3/16/15. 12. Interview on 3/2/15 at 9:30 AM with resident #1 revealed s/he had to wait for over an hour to get assistance to the bathroom "one night this past week" because there was not enough staff on duty. 13. During an interview on 3/2/15 at 6:40 PM resident #14 stated it was difficult to get assistance when the facility was short of staff. The resident further stated s/he was trying to pull	F 353		

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F 353	Continued From page 15 up his/her pants last week and only "got them up part way." S/he activated the call light for assistance to complete the task and waited an hour and a half with the pants half way on until staff responded. The resident further stated s/he liked to eat the evening meal in his/her room, but did not receive a supper tray until 8:45 PM last night. 14. Interview on 3/3/15 at 8:50 PM with a family member of resident #13 revealed s/he visited the facility approximately three time per week. She stated call lights were often not answered for over 30 minutes, and care which included toileting residents and assisting residents with eating, was not timely. The family member further said she attributed the lack of timely provision of care to inadequate staffing.	F 353		
F 441 SS=E	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	F 441	**F 441: INFECTION CONTROL, PREVENT SPREAD, LINENS** 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** An SBAR was completed which included physician and family notification and care plan was written for resident #10 to address infection. The care plan included condition requiring precautions,	

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F 441	Continued From page 16 (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 and resident interview, medical record review, and review of facility policies and procedures and infection control documentation, the facility failed to ensure staff followed infection control standards of practice while caring for 1 of 14 sample residents (#10) who had signs and symptoms of gastrointestinal infection. The findings were: 1. On 2/26/15 at 12:26 PM the state epidemiology department notified the state survey agency of a gastrointestinal outbreak in the facility. As of 2/26/15, 28 residents and staff were experiencing vomiting and diarrhea. The first person became ill on 2/20/15. On 3/6/15 at 12:37 PM, the epidemiology reported Norovirus was confirmed in samples from the residents tested.	F 441	type of infection prevention precautions. Resident #10's symptoms were resolved. **Identification of Others** 24 hour reports week were reviewed by the SDC to determine residents that has symptoms of gastrointestinal illness. The SDC or designee completed SBAR's which included physician and family notifications and updated care plans for those identified. **Systemic Changes** The Staff Development Coordinator will educate staff by 4/1 on infection prevention precautions, including when to use PPE, when to wash hands, gloving, and when to wear gowns. Education will include Norovirus protocol. The Director of Nursing or designee will educate nurses by 4/1 on evaluating change of condition, documenting, physician and family notification developing care plans for those with infections, including condition requiring infection precautions, type of infection precautions.	

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F 441	Continued From page 17 2. Review of the medical record for resident #10 showed s/he was admitted to the facility on 9/2/13 with diagnoses which included end stage renal disease and recent kidney transplant. Review of physician orders showed a 9/15/14 order for Tacrolimus (immunosuppressant agent) 0.5 mg by mouth daily. Review of the 2010 Drug Information Handbook for Nursing showed information for Tacrolimus which included, "Increased susceptibility to infection...may result from immunosuppression with tacrolimus." Interview with CNA #8 on 3/2/15 at 1:50 PM showed the resident was not feeling well. Interview with the resident at that time revealed s/he had vomiting earlier in the morning and continued to have diarrhea. The resident further stated that nursing staff were aware. The following concerns were identified: a. Observation on 3/2/15 at 1:50 PM showed there was no personal protective equipment in or by the door of the resident's room (except gloves). b. Observation on 3/2/15 at 2:05 PM showed LPN #2 and CNA #9 assisted the resident in his/her room due to the resident having diarrhea. Diarrhea stool was visible on the resident's bed. At that time the LPN washed her hands and donned gloves. She then removed the soiled linens and cleaned the bed with use of the appropriate bleach wipes. At that time the CNA assisted the resident to the bathroom and changed the diarrhea soiled brief and assisted with personal care after washing her hands and donning gloves. However, the LPN and CNA failed to wear a gown or other protection for their personal clothing during this care. After washing their hands both the LPN and CNA left the resident's room to care for other residents.	F 441	and new physician orders will be reviewed 3 times per week at morning interdisciplinary team meeting by Director of Nursing or designee. A communication tool will be used to The 24 hour report, new telephone orders communicate infection and precautions to the staff. Documentation, notifications and care plans will checked after meeting to determine if new infections or changes in infections are addressed. **Monitoring** The Staff Development Coordinator or designee will round on residents with infections 3 times per week for 30 days and then weekly for 2 months to monitor infection precautions, staff performance, and knowledge of reason for precautions, documentation, care plans. Corrective actions will be taken as needed. The Staff Development Coordinator or designee will track and trend the results of the infection control audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the	

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F 441	Continued From page 18 3. Interview with the ICP and DON on 3/3/15 at 6:05 PM revealed staff were required to wear PPE which would include a gown to protect personal clothing when assisting with care or handling linens of a resident with gastrointestinal symptoms which would include diarrhea. 4. Review of the facility's policy on contact precautions, reviewed 2009, showed the purpose of the policy on contact precautions was: "It is the intent of this facility to use contact precautions in addition to Standard Precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Further the policy showed instructions included "III. GOWNS, A. A gown should be donned prior to entering the room or resident's cubicle. B. The gown should be removed before leaving the resident's room. C. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces."	F 441	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-467 ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC** It is a practice of the facility to ensure that areas that require outside ventilation have an adequate system in place. **Corrective Action** The bathroom ventilation fans in rooms #104, #114, #202, #206, #305, #306, #407, #412, #504, #512, #513, #605, and #608 will be removed and replaced no later than ~~7/31/2015.~~ 4/30/15 4/2/15 aa **Identification of others** A facility wide audit was conducted with all the ventilation fans in resident rooms as well as all ventilation fans in other rooms/areas of the facility. Ventilation fans that were found to have failed the ventilation	4/30/15
F 467 SS=F	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate ventilation to minimize noticeable odors in 6 of 6 hallways (100 hallway, 200 hallway, 300 hallway, 400 hallway, 500 hallway, 600 hallway). The findings were:	F 467		

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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 467	Continued From page 19 Periodic observations from 3/1/15 at 9:15 PM through 3/4/15 at 12:05 PM revealed from the front doorway throughout the building in all 6 hallways the facility had a noticeable odor of urine and stool. On 3/2/15 from 10:35 AM through 1:35 PM a sample of resident room bathroom exhaust fans were checked for ventilation adequacy with use of a Kleenex (used to determine whether or not the fan successfully pulls air). The following concerns were identified: a. On 3/2/15 from 10:45 AM through 1:35 PM the following resident bathroom exhaust fans failed to pull a Kleenex and the air in rooms: #104, #114, #202, #206, #306, #308, #407, #412, #504, #512, #513, #605, and #608. The bathrooms had noticeable odors of stale urine and stool. b. On 3/3/15 from 9 AM though 10:10 AM the test was repeated in each of the failed rooms, and the test results remained the same. The exhaust fans failed to pull air. c. Interview with the maintenance director on 3/3/15 at 10:15 AM revealed he had been in the position for 2 weeks and was unsure when the exhaust fans were last checked. He declined when asked to follow the surveyor to re-test the exhaust fans. At that time the maintenance director confirmed he was unaware of a specific plan with a timeframe to address the exhaust fans.	F 467	adequacy test (Kleenex test) will be removed and replaced no later than ~~7/31/15.~~ 4/30/15 CM **Systemic Changes** A waiver request will be submitted to the Office of Healthcare Licensure and Survey no later than April 2. The request will contain a time frame for removing and replacing the ventilation fans noted in the corrective action and any additional ventilation fans in bathroom/rooms that were found to not have adequate outside ventilation using a Kleenex test in a 120 day timeframe. **Monitoring** The Maintenance Director will test 5 bathroom/room fans for adequate outside ventilation using the Kleenex test weekly then 5 monthly thereafter for 6 months. Fans that fail the test will be removed and replaced within a reasonable timeframe. The Maintenance Director will submit a report on fan replacement monthly to the QAPI for review and corrective actions taken if necessary.	

3/31/15