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

PRINTED: 03/31/2015
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 03/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| POPLAR LIVING CENTER | 4306 S POPLAR CASPER, WY 82601 |

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| F 000 | INITIAL COMMENTS<br><br>On 3/16/15 - 3/18/15 a complaint survey was conducted at Poplar Living Center. The survey was prompted by complaint intake WY00002004.<br><br>The following common abbreviations are used throughout this document:<br><br>ADL - Activities of Daily Living<br>CNA - Certified Nurse Aide<br>DON - Director of Nursing<br>IAD - Incontinence Associated Dermatitis (an inflammation of the skin that occurs when urine or stool comes into contact with perineal or perigenital skin)<br>MDS - Minimum Data Set<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>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 | F 157 | **F-157: NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)**<br><br>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. | 4/8/15 TD |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 4/7/15

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.

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FORM CMS-2567(02-99) Previous Versions Obsolete WY Dept of Health — Event ID: 44LP11 — Facility ID: WY0023 — If continuation sheet Page 1 of 10

4/10/15 @ 3pm This POC accepted between Tony Janusz, administrator and Pat Prince, Surveyor, with DOC of 4/13/15.

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| F 167 | Continued From page 1<br>§483.12(a).<br><br>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.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, family interview, and staff interview, the facility failed to notify the family of the change in condition for 1 of 6 sample residents (#2) who experienced a significant change in condition. The findings were:<br><br>Review of the 1/7/15 quarterly MDS assessment showed diagnoses for resident #2 included dementia, coronary artery disease, and atrial fibrillation. This review showed the resident was totally dependent on staff for repositioning, transfers, and incontinent care; and s/he did not have wounds, pressure ulcers, arterial ulcers or venous ulcers. Review of the nursing notes showed the resident was transported to the hospital on 3/6/15 due to wounds and cellulitis. The following concerns were identified:<br>a. Interview with CNA #1 on 3/17/15 at 2:30 PM revealed there were red and open areas on the resident's buttocks for over a week before the resident was transported to the hospital and | F 157 | The facility strives to ensure family, physician, legal representative, and interested family members are notified when their family member has a significant change in condition which included skin condition.<br><br>**Corrective Action:**<br>Resident #2's family member has been notified of their family member's change of condition related to skin and is documented in the resident's Medical Record (MR).<br><br>**Identification of Others:**<br>The Director of Nurses (DON) has reviewed the last two weeks of 24 hour report for any residents who have had a significant change of condition including skin condition. The DON completed SBAR's which includes notifications of family and physician for those identified as not compliant with F-157.<br><br>**Systemic Changes:**<br>Staff was educated on F-157: "Notify of Changes (Injury/Decline/Room, Etc)" by 4/2/2015 by the DON.<br><br>The 24 hour report, new telephone orders and new physician orders will be reviewed at morning IDT meeting by the DON or designee. | |

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| F 157 | Continued From page 2<br>the nurses put a cream on it. She further stated the sores on the resident's buttocks and swollen red areas on the resident's legs continued to worsen.<br>b. Interview with the family member on 3/16/15 at 6:50 PM revealed the family member identified the extensive swelling and redness on resident's legs and brought it to the nursing staff's attention on 3/5/15. This family member further stated the development of the cellulitis and wounds had not been reported to the family member prior to 3/5/15.<br>c. Interview with Licensed Practical Nurse (LPN) #1 on 3/16/15 at 7:30 PM revealed she noted the resident's swollen legs on 3/4/15 and it worsened on 3/5/15. The LPN confirmed the family member identified the worsened condition on 3/5/15 and asked the nurses to assess the areas. | F 157 | Documentation of nurses' notifications to family and physician per F157 of Change of Conditions will be checked for compliance. Noncompliance will be corrected promptly and corrective action taken when necessary.<br><br>**Monitoring:**<br>A random audit of residents with change of condition will be completed weekly by the DON or designee for 30 days and then monthly for 2 months. The audit will include documentation of family and physician notification per F157<br><br>The DON will track and trend the results of the audit and report findings to the QAPI committee monthly for review and corrective action when necessary. | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and medical record review, the facility failed to provide appropriate skin care assessments, monitoring, and treatments for 2 of 6 sample residents (#2, #10) with wounds. This failure resulted in actual | F 309 | **F-309: PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>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 | 4/15/15 |

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| F 309 | Continued From page 3<br>harm for resident #2 who required inpatient hospitalization for wound care. The findings were:<br><br>1. Review of the 1/7/15 quarterly MDS assessment showed diagnoses for resident #2 included dementia, coronary artery disease, and atrial fibrillation. This review showed the resident was totally dependent on staff for repositioning, transfers, and incontinent care; and s/he did not have wounds, pressure ulcers, arterial ulcers or venous ulcers. The following concerns were identified:<br><br>a. Review of the care plan for resident #2 showed staff were directed to observe skin weekly and document findings as indicated. Review of the February and March 2015 nursing notes, bath records, and weekly skin assessments showed no evidence a skin assessment was done from 2/24/15 to 3/6/15 (9 days).<br><br>b. Review of the skin assessments dated 2/3/15, 2/10/15, 2/17/15, and 2/24/15 showed staff identified redness on the buttocks on 2/3/15 and redness on the coccyx on 2/24/15. This review showed no documented findings of more than redness at any other time.<br><br>c. Interview with CNA #1 on 3/17/15 at 2:30 PM revealed there were red and open areas on the resident's buttocks for over a week before the resident was transported to the hospital and the nurses put a cream on it. She further stated the sores on the resident's buttocks and swollen red areas on the resident's legs continued to worsen.<br><br>d. Review of the nursing notes showed the resident was transported to the hospital on 3/6/15 due to wounds and cellulitis that were first noted on 3/5/15. Review of the hospital physician's note, dated 3/6/15, revealed the | F 309 | accordance with the comprehensive assessment and plan of care.<br><br>**Corrective Action:**<br>Resident #2's wounds were evaluated by the Director of Nursing on 3/23/2015 and documented on the Individual Non Pressure Skin Condition form and was placed in the medical record. Resident #10's wounds were evaluated by Director of Nursing on 3/23/2015 and documented on the Individual Non Pressure Skin Condition form and was placed in the medical record. The physician was contacted and treatment orders were clarified for resident #10 on 3/22/2015.<br><br>**Identification of Others:**<br>Head to toe skin evaluations, 24 hour reports and pressure and non pressure skin condition forms were reviewed by the Director of Nursing / designee to determine residents that have wounds or skin concerns. The Director of Nursing or designee has evaluated the wounds and documented findings on the Pressure or Non Pressure Skin condition form and placed the documentation in the medical record. SBAR's which included evaluation, physician and family notifications, treatment orders | |

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| F 309 | Continued From page 4<br>resident had multiple ulcerated skin areas and right leg cellulitis. Further review of this physician's note showed the resident was admitted with the following wounds: "...deep tissue injury" mostly on the left sacral area, right leg swelling with increased redness and warmth on the foot up to the mid shin, an area of redness centered around necrotic tissue over the lateral aspect of the right knee, a necrotic ulcer facing the lateral aspect of the distal part of the fifth toe, and an ulceration on the left foot. Review of the hospital records showed the resident returned to the facility on 3/11/15 with orders for continued intravenous antibiotic therapy and treatments for the wounds.<br>e. Observation of the resident with the DON on 3/16/15 at 7:30 PM revealed a dark purple area on the sacrum, both buttocks and coccyx surrounded a 4.4 centimeters (cm) by 5.5 cm open yellow area. This open area had serosanguineous drainage. There were additional wounds on both feet, legs, and right knee and necrotic tissue was observed on the edges of the wounds on the feet and right knee. Interview with the DON at that time revealed the wounds were present before the resident went to the hospital. She further stated the wound on the sacrum, buttocks and coccyx was an IAD caused by diarrhea from a gastrointestinal virus; and the wounds on both legs were due to cellulitis. Review of the bowel records and interview with the infection control nurse on 3/17/15 at 7:10 PM revealed the resident did not have diarrhea episodes after the 2/24/15 skin assessment which showed only redness. In addition, review of the medication administration record showed the resident received a laxative on 3/3/15 due to "no BM (bowel movement)."<br>f. Review of the skin care monitoring | F 309 | and updated care plans for those identified were completed.<br><br>**Systemic Changes:**<br>The Director of Nursing or designee has educated nurses on completion of head to toe skin evaluations weekly and documentation of findings. Education will include steps to take if new skin concerns are identified.<br><br>The Director of Nursing or designee has educated licensed nurses on evaluating change of condition, documenting, physician and family notification and developing care plans for those with wounds.<br><br>The 24 hour report, new telephone orders and new physician orders will be reviewed 3 times per week at morning interdisciplinary team meeting by Director of Nursing or designee. Documentation of nurse's evaluation, family and physician notifications and care plans will be checked to determine if new wounds or skin concerns are addressed.<br><br>The Director of Nursing or designee will continue weekly wound rounds to evaluate and measure wounds. The findings will be documented on the Weekly Pressure or Non Pressure | |

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| F 309 | Continued From page 5<br>system on 3/17/15 revealed the facility had not implemented a system for ensuring the resident received incontinent care in a timely manner to prevent worsening of the existing IAD and prevent development of IAD. During an interview on 3/18/15 at 2:55 PM the DON acknowledged the lack of a system for monitoring for IAD. She further verified there were problems with the skin monitoring system and she was working to resolve those problems.<br>g. During an interview on 3/16/15 at 7:30 PM, the DON stated the wounds on the resident's feet were due to circulatory problems. Review of the hospital and facility physicians' documentation revealed no evidence of a physician's determination that these wounds were unavoidable due to circulatory problems. In an interview on 3/18/15 at 2:55 PM, the DON verified the lack of this evidence.<br><br>2. Review of the 11/25/14 admission nursing assessment showed resident #10 was admitted to the facility with venous stasis ulcers on the legs. Review of the 2/19/15 quarterly MDS assessment showed diagnoses included coronary artery disease and chronic pain due to trauma. Further review showed the resident was alert and oriented, and required extensive assistance with most ADLs. Review of the care plan, updated 3/16/15, showed the resident was bedridden due to a cervical fracture. Further review of the care plan showed staff were to provide wound care as ordered for a chronic venous stasis ulcer on the left leg. Review of the 3/2/15 and 3/9/15 weekly skin assessments showed the venous stasis ulcer on the left leg measured 15 cm x 12 cm x .2 cm, had macerated edges, and was red with serosanguineous drainage. The following concerns were identified: | F 309 | Skin condition forms weekly and the forms will be placed in the medical record.<br><br>**Monitoring:**<br>The Director of Nursing or designee will review change of conditions 4 to 5 times a week for one month and then review 5 change of conditions weekly for 2 months. The audit will include documentation of nurse evaluation in medical record, follow up documentation, physician and family notification and care plans updates. Corrective actions will be taken as needed for any identified concerns.<br><br>Random weekly audits of residents with skin conditions will be completed by the Director of Nursing or designee for presence of accurate and timely documentation of wounds in the medical record and presence of treatment orders. The audit will be completed weekly for 3 months Corrective actions will be taken as needed.<br><br>The Director of Nursing or designee will track and trend the results of the change of condition documentation audits and the skin management audits and report findings to the | |

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| F 309 | Continued From page 6<br>a. Review of the weekly skin assessments and treatment records from 11/25/14 to 3/6/15 showed no evidence staff had obtained treatment orders for the venous stasis ulcer.<br>b. Review of the skin assessments, treatment records, and nurses' notes from 11/25/14 to 3/6/15 revealed wound care was provided, but it was unclear what that care entailed and the frequency it was provided.<br>c. Review of the physician's progress note, dated 3/6/15, revealed the nursing staff had not monitored the area and they had been changing the dressings "from time to time." Further review showed the physician ordered an antibiotic and Silvadene (an external antimicrobial cream) with daily dressing changes to remove the "necrotic tissue."<br>d. In an interview on 3/18/15 at 2:55 PM, the DON confirmed the lack of monitoring and treatment orders. During the interview the DON did not identify a system that had been implemented to prevent reoccurring incidents of staff failure to obtain prescribed treatments for venous/stasis ulcers. | F 309 | 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.<br><br>**F-514: RECORDS COMPLETE / ACCURATE / ACCESSIBLE**<br><br>The facility strives to maintain clinical records on each resident in accordance with professional standards.<br><br>**Corrective Action:**<br>The Director of Nursing has received education from the District Clinical Director on skin management policies, including documentation of wounds on Pressure and Non-Pressure Skin Condition forms and placement of forms in medical record.<br><br>The wound documentation referenced in the Statement of Deficiencies on resident's #2, 6, 7 and 8 have been amended by the Director of Nursing to indicate these were late entries. | RP 4/18/15 |
| F 514 SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any | F 514 | | |

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| F 514 | Continued From page 7<br>preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure the medical record was complete, accurate and readily accessible for 4 of 10 sample residents (#2, #6, #7, #8) reviewed for wound assessments. The findings were:<br><br>1. Observation on 3/18/15 at 10:45 AM showed the DON was transcribing information from the Quality Assurance (QA) skin documentation book to a form for placement in the medical record. Interview on 3/18/15 at 3:05 PM with the DON and administrator revealed the DON was trained to document and track wound assessments in the QA book, not in the medical record.<br><br>2. Review of the 1/7/15 quarterly MDS assessment showed diagnoses for resident #2 included dementia, coronary artery disease, and atrial fibrillation. Review of the nursing notes showed the resident was transported to the hospital on 3/6/15 due to wounds and cellulitis that were first noted on 3/5/15. Review of the hospital physician's note, dated 3/6/15, revealed the resident had multiple ulcerated skin areas and right leg cellulitis. Review of the facility readmission orders showed the resident returned to the facility on 3/11/15. Review of the entire medical record revealed no records of wound assessments for March 2015. On 3/18/15, the DON produced wound assessment documentation dated 3/5/15 and 3/13/15 which were not marked as a late entry, and were | F 514 | **Identification of Others:**<br>An audit of Head to Toe Skin Evaluations for timely completion was completed by the Director of Nursing. Any missing or late evaluations have been completed.<br><br>Head to toe skin evaluations will be reviewed for identified skin concerns by the Director of Nursing or Designee. For those identified with wounds an audit will be conducted for complete, accurate, timely and readily accessible documentation of wounds in medical record, timely physician and family notification, care plan and treatment interventions. Corrective actions will be taken as needed.<br><br>**Systemic Changes:**<br>The Director of Nursing or designee has educated nurses on completion and accuracy of head to toe skin evaluations weekly and documentation of findings. Education will include steps to take if new skin concerns are identified.<br><br>The Director of Nursing or designee has educate licensed nurses on evaluating change of condition, documenting, physician and family | |

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| F 514 | Continued From page 8<br>previously not available in the medical record.<br><br>3. Review of the 1/2/15 quarterly MDS assessment showed resident #8 had diagnoses that included diabetes mellitus and unspecified ulcer of lower limb, and needed extensive assistance with ADLs. Review of the care plan updated 1/9/15 showed "BLE [bilateral lower extremities] stasis ulcers." Review of the entire medical record revealed no documentation of wound assessments. On 3/17/15 the DON produced wound assessment documentation dating back to 1/5/15, which were not marked as a late entry, and were not previously available in the medical record.<br><br>4. Review of the 2/10/15 quarterly MDS assessment showed resident #7 had diagnoses that included diabetes mellitus, peripheral vascular disease, and traumatic below the knee amputation, and needed extensive assistance with ADLs. The resident was admitted to the facility on 6/26/14 with a stage 4 pressure ulcer. Review of the entire medical record revealed no documentation of a wound assessment. On 3/17/15 the DON produced wound assessment documentation from the resident's medical record dating back to 2/2/15, which were not marked as a late entry, and were not previously available in the medical record.<br><br>5. Review of the 1/13/15 quarterly MDS assessment showed resident #8 had diagnoses that included wound infection, diabetes mellitus and needed extensive assistance with activities of daily living. The resident was admitted 10/30/14 with a surgical site wound and methicillin sensitive staphylococcus aureus (MSSA) infection. Review of the entire medical record | F 514 | notification and developing care plans for those with wounds.<br><br>The 24 hour report, new telephone orders and new physician orders will be reviewed 3 times per week at morning interdisciplinary team meeting by Director of Nursing or designee. Documentation of nurse's evaluation, notifications and care plans will be checked at the meeting to determine if new wounds or skin concerns are addressed.<br><br>The Director of Nursing or designee will continue weekly wound rounds to evaluate and measure wounds. The findings will be documented on the Weekly Pressure or Non Pressure Skin Condition forms weekly and the form will be placed in the medical record.<br><br>**Monitoring:**<br>The Director of Nursing or designee will review change of conditions 4 to 5 times a week for one month, and then 5 change of conditions weekly for 2 months. The audit will include documentation of nurse evaluation in medical record, follow up documentation, physician and family notification and care plans updates. Corrective actions will be taken as needed for any identified concerns. | |

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

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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 03/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| POPLAR LIVING CENTER | 4308 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 514 | Continued From page 9<br>revealed no record of wound assessments. On 3/18/15 the DON produced wound assessment documentation dating back to 12/15/14, which were not marked as a late entry, and were not previously available in the medical record. | F 514 | Random weekly audits of medical record for skin condition documentation will be completed by the Director of Nursing or designee for 3 months. Corrective action will be taken as needed.<br><br>The Director of Nursing or designee will audit head to toe skin evaluations for completion weekly for 4 weeks and then complete a random audit weekly for 2 months.<br><br>The Director of Nursing or designee will track and trend the results of the change of condition documentation audits skin management 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. | |