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

Form Approved
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	04/16/2015

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 F0166 Reg. # 483.10(f)(2) LSC	04/16/2015	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4 LSC	04/16/2015	ID Prefix F0309 Reg. # 483.25 LSC	04/16/2015
ID Prefix F0315 Reg. # 483.25(d) LSC	04/16/2015	ID Prefix F0353 Reg. # 483.30(a) LSC	04/16/2015	ID Prefix F0467 Reg. # 483.70(h)(2) LSC	04/16/2015
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:
	B 4/23/15			4/20/15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	

Followup to Survey Completed on: ___

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

4/23/15

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	535024	A. BUILDING _____ B. WING _____	R-C 04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 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 A re-visit survey was conducted by the Office of Healthcare Licensing and Surveys on 4/14/15 through 4/16/15. This survey was prompted by findings from surveys conducted on 1/6/15, 3/4/15, and 3/18/15.	{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.	4/22/15
{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 (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.	{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** Resident #48's room, was immediately sanitized, including call bell, cleaning of lift and wheelchair, by housekeeping staff after findings were reported by surveyor. Resident #48's catheter drainage bag was cleaned and clothing was changed by nursing staff immediately after findings were reported by surveyor. Immediate	

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

Administrator 4/22/15

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.

Accepted on 4/23/15 spoke w/NHA

Tony Jaggers in charge to pg 3.

4/20/15

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DOC = 4/22/15

4/23/15

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(F 441)	Continued From page 1 (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, medical record review, staff interview, and review of policy and procedure, the facility failed to implement effective infection control practices. During random observations the facility failed to ensure acceptable hand hygiene procedures were followed, failed to ensure contact precautions were maintained related to cleaning, and failed to prevent the availability of spoiled food. These findings affected the care of residents #48 and #37 and had the potential to affect other residents in the facility. The findings were: 1. Medical record review showed resident #48 resided in room 312, and review of the care plan dated 4/1/15 showed the resident was on contact isolation precautions. Review of the physician progress note, undated, showed the resident was on the antibiotic Vancomycin for a diagnosis of Clostridium difficile colitis (inflammation of the large intestine resulting from infection with Clostridium difficile (C. Diff.) bacterial infection). Observation on 4/14/15 at 4:30 PM showed certified nurse aide (CNA) #1 and #2 assisted resident #48 out of bed with the sit-to-stand lift. The following concerns were identified: a. After the resident was standing with the aid of the lift, both CNAs removed the resident's brief with gloved hands. CNA #2 cleansed the	(F 441)	education with return demonstration was completed with the employees involved. Immediately after the occurrence of failure of Resident Assistant to wash hands was reported by the surveyor the water pitchers that had been passed to rooms 312, 304, 310, and 311 were removed and replaced. Education was completed with the Resident Assistant. Immediately after the surveyor reported the soiled floor the floor was cleaned and sanitized by the housekeeping staff. The registered dietician and dietary manager have met with resident #37 and developed a plan for managing the juice that she requests. Her care plan has been updated to reflect the changes. Aseptic juice, that does not require refrigeration, has been purchased and is being brought to her room 3 times daily with delivery of room trays. **Identification of Others** An Infection Control Checklist, which included observations, was completed facility wide in resident's rooms to	

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{F 441}	Continued From page 2 resident's perineum in the front, while CNA #1 cleansed the resident's buttocks in the back. The wipe that was used to clean the resident's buttocks was visibly soiled. The CNAs failed to remove their soiled gloves, and proceeded to touch the resident and his/her shirt, the resident's wheelchair, the sit-to-stand lift, the resident's urine drainage tubing and down-drain bag, and the resident's call light. CNA #2 then used bleach wipes to clean several areas she had touched in the resident's room; however, she failed to remove her soiled gloves before cleaning the items. CNA #1 left the resident's room without performing hand hygiene. CNA #2 left the resident's room without performing hand hygiene, walked down the hall to the common area, and used the sink in the sitting room to wash her hands. b. Interview at 4:40 PM that day with CNA #2 verified she did not remove her gloves after performing perineal care for the resident. c. Interview on 4/14/15 at 4:45 PM with the infection preventionist (IP) revealed her expectation was for the staff members to change their gloves after providing perineal care; perform hand hygiene after any glove changes, not use their soiled gloves to touch the resident nor any items in the resident's room, and the staff should have used the sink in the resident's room to wash their hands before they left the resident's room. d. Review of the facility policy titled "Hand Hygiene" dated 2012 showed, "Handwashing ...after providing care to a resident with a spore-forming organism (e.g. C. Difficile), perform hand hygiene with ...soap and water." e. According to the Center for Disease Control (CDC) Guideline for Hand Hygiene in Health-Care Settings dated October 2002, " HCWs [health care workers] can contaminate	{F 441}	identify infection control concerns including food/beverage storage. Corrective action was taken for any identified concerns. Skills checks for management of isolation precautions, including glove use and hand washing was completed with nursing staff working with resident's currently on contact precautions to identify any concerns. Corrective action will be taken as needed. **Systemic Changes** The Staff Development Coordinator will educate staff by on infection prevention precautions, including when to use PPE, when to wash hands, gloving, and when to wear gowns. New employees will be educated during orientation period and validated with skills observation. The Staff Development Coordinator or designee will educate staff on basic food storage, including how long food / beverage items can be left at bedside unrefrigerated. New employees will be educated during orientation period. The Staff Development Coordinator or designee will round on residents with	4/22/15 all staff Educated per Tony Jaramoz NHA on 4/23/15

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{F 441}	Continued From page 3 their hands with gram-negative bacilli, S. aureus, enterococci, or Clostridium difficile by performing 'clean procedures' or touching intact areas of the skin of hospitalized patients ...HCWs should be encouraged to wear gloves when caring for patients with C. difficile-associated diarrhea (226). After gloves are removed, hands should be washed with ...soap and water or disinfected with an alcohol-based hand rub. During outbreaks of C. difficile-related infections, washing hands with ...soap and water after removing gloves is prudent ...hands should be decontaminated or washed after removing gloves." 2. Medical record review showed resident #48 resided in room 312, and review of the care plan dated 4/1/15 showed the resident was on contact isolation precautions. Review of the physician progress note, undated, showed the resident was on the antibiotic Vancomycin for a diagnosis of Clostridium difficile colitis (inflammation of the large intestine resulting from infection with Clostridium difficile (C. Diff.) bacterial infection). The following concerns were noted: a. Observation on 4/14/15 from 1:45 PM to 2 PM showed resident assistant (RA) #1 removed used water mugs and delivered clean water mugs to several rooms. At 1:45 PM she entered room 312, which had a posted precaution sign for resident #48, the RA gowned and gloved to enter the room. The RA delivered a clean water mug to the room and removed the used water mug. When the RA left the resident's room she discarded the used personal protective equipment including the gloves; however, she did not perform hand hygiene. The RA then entered another resident's room without performing hand hygiene to exchange that resident's mug. This room was not posted with any precautions. The	{F 441}	infections 3 times per week to monitor infection precautions and staff performance. **Monitoring** The Staff Development Coordinator or designee will complete random audit 3 times weekly for one month and then weekly for 2 months of residents on infection control precautions. The audit will include visual observation of staff performance in care of those on precautions, staff knowledge of reason for precautions. Corrective actions will be taken as needed for any identified concerns. The Staff Development Coordinator or designee will complete Infection Control Checklist randomly on each hall 3 times weekly for one month and then weekly for 2 months. The checklist includes observation of food / beverage storage in resident room. Corrective action will be taken as needed for identified concerns. The Staff Development Coordinator or designee will track and trend the results of the infection control audits and report findings to the Infection Control QA Subcommittee weekly.	

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{F 441}	Continued From page 4 continued observation showed the RA performed the same task for resident rooms 304, 310, and 311 without performing any hand hygiene. b. Interview on 4/14/15 at 2 PM with RA #1 verified she did not perform hand hygiene between resident rooms. 3. Observation on 4/15/15 at 3:05 PM showed the floor outside of resident room 301 was soiled. There were 5 areas with what appeared to be dried feces in a pattern leading in/out the room. Room 301 was marked with signage to indicate contact precautions were in place. The floor inside the resident room was also visibly soiled with areas of what appeared to be dried feces. Interview with the IP on 4/15/15 at 3:15 PM verified the areas were likely feces and needed to be cleaned, and she initiated the proper procedure at that time. She further stated the resident in the room (#33) was on contact precautions related to clostridium difficile bacterial infection. Additional interview with the IP on 4/15/15 at 3:32 PM revealed she had inquired about the resident's care with the CNA and resident assistant (RA) working with the resident. They reported to her the resident had an incontinent bowel episode after breakfast that day, and as the staff wheeled the resident into the room in the wheelchair there was dripping of the incontinent bowel movement onto the floor. According to the IP, the RA and the CNA should have cleaned the floor at that time with bleach wipes and then contacted housekeeping for a thorough cleaning of the area. 4. Review of the 3/2/15 quarterly Minimum Data Set assessment showed resident #37 was cognitively intact with a brief interview for mental status (BIMS) score of 15/15. The resident was	(F 441)	The Infection control subcommittee will report 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.	

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{F 441}	Continued From page 5 observed on 4/14/15 at 3:33 PM to be in bed with beverages available on the over-bed table. Interview with the resident on 4/14/15 at 4:40 PM revealed s/he was bed bound and had been experiencing nausea and diarrhea for two days. The resident further revealed s/he had reported these symptoms to the nurse. Review of the medical record showed on 4/14/15 the nurse faxed the physician a communication related to the nausea. There was no mention of diarrhea. Interview with the nurse on 4/14/15 at 6:05 PM verified she was unaware the resident had any diarrhea. Observation while interviewing the resident on 4/14/15 at 4:40 PM showed 3 glasses of liquid on the resident's over-bed table. Next to these three glasses were 3 plastic sealed containers of apple juice. Interview with the resident at that time verified the liquid in the glasses was apple juice. She stated throughout the day s/he poured the juice from the plastic containers into the cups so s/he could better handle it and then drink it with a straw. The resident stated s/he liked to keep several juices available at all times on the table, and this had been his/her system for about 5 months. The following concerns were identified: a. Closer inspection of the poured glasses of juice on 4/14/15 at 6:50 PM revealed a sediment ring and film on the interior of the glass with the straw, which the resident was drinking from. Another glass filled with juice had a film on the surface and small bubbles around the interior edge of the liquid. The juice smelled fermented/spoiled in two of the three glasses including the one the resident was drinking from with a straw. The 3 unopened plastic cups of apple juice were at room temperature when handled. The packaging showed "keep refrigerated." There was no date or time written	{F 441}		

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{F 441}	Continued From page 6 on these sealed cups to show when they were removed from refrigeration and delivered to the resident. b. Interview with the resident at that time stated the glasses did not get cleaned often because s/he didn't want staff to take the cups. These cups were the only ones that fit his/her hands. The resident then stated s/he would allow them to be washed as long as they were returned. c. Interview with customer service employee #1 on 4/14/15 at 6:55 PM revealed the juice cups did not get cleaned as regularly as needed for this resident because the resident often refused to allow them to take away the glasses. d. At 6:55 PM on 4/14/15 staff member #1 removed the cups of apple juice from the resident's table. At that time the staff member verified the apple juice in the cups smelled spoiled and the cups did not appear clean and the surface of the juice appeared to have a film on two of the three cups. e. Interview with the dietary manager on 4/15/15 at 1:05 PM revealed she was unaware the resident was storing the apple juices for later use. Observation of the resident's room tray and over-bed table at that time showed the resident had 3 plastic sealed cups of juice on the table and three poured glasses of juice. There was no label to know when they were delivered. The dietary manager stated she was aware the juice required refrigeration and verified there would need to be a date and time to show how long the juice was out of refrigeration to ensure it was at a safe temperature and did not spoil.	{F 441}		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 7 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, observation, and review of policy and procedure, the facility failed to implement an effective quality assessment and assurance (QAA) program to identify and correct previously identified deficiencies related to infection control practices. The findings were: Review of previous survey findings revealed deficiencies related to infection control were cited on the 1/9/14 recertification survey, the 5/16/14	F 520	**F-520: QAA-MEMBERS/MEET QUARTERLY/PLANS** It is the practice of the facility to maintain a quality assurance committee consisting of the DON, a physician designated by the facility, and at least 3 other members of the facility staff. **Corrective Actions** The Infection Control Committee (ICC) met on 4/22/2015 to review and revise the surveillance and implementation of effective monitoring tools related to hand hygiene and environmental cleaning. The registered dietician and dietary manager have met with resident #37 and developed a plan for managing the juice that she requests. Her care plan has been updated to reflect the changes. Aseptic juice, that does not require refrigeration, has been purchased and is being brought to her room 3 times daily by dietary staff. **Systemic Changes** The Corporate Representative has educated the ICC on the proper implementation of the QAA program	4/22/15

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F 520	Continued From page 8 complaint survey, the 8/15/14 complaint survey and remained uncorrected on the 10/1/14 follow-up survey. The deficiency was determined to be corrected on 10/29/14, but was cited again during the complaint survey on 3/4/15. The date of compliance for the 3/4/15 deficiency was 4/3/15. Observation during the survey from 4/14/15 to 4/16/15 showed examples of infection control issues. These observations included a lack of hand hygiene and environmental cleaning to prevent the transmission of infections. In addition, there was an identified concern related to the availability of spoiled food for one resident (#37). Refer to F 441 for details. Interview with the administrator, the corporate representative, and director of nursing on 4/16/15 at 10:45 AM revealed the hours the infection prevention nurse was assigned other duties had been reduced but she continued to be needed to work as a staff nurse at various times. The interview further revealed the QAA measures had improved but continued work was needed regarding surveillance and implementing an effective monitoring tool related to these issues.	F 520	as it relates to infection control practices on 4/22/2015. The Staff Development Coordinator or designee will track and trend the results of the infection control audits and report findings to the ICC committee weekly for 4 weeks then monthly thereafter. The ICC 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. The Staff Development Coordinator or Designee will present a monthly report to the QAPI Committee monthly meeting for review and corrective actions taken where necessary. **Monitoring** The QAPI monthly meeting minutes will be presented to the Corporate Representative or designee for review and corrective actions taken where necessary.	