Hand Delivered

RECEIVED
MAY 12 2015
Healthcare Licensing

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

5/28/15

PRINTED: 05/14/2015
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 04/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 4/28/15 through 4/30/15. The survey was prompted by complaint intakes WY00001951, WY00001954, WY00001974, WY00002009, and WY00002019. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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.	
F 225 SS=E	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,	F 225	**F-225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** **Corrective Actions:** CNA's #1, #2, #3, #4, and #5 have been registered and have documentation to show the state nurse aide registry was checked to verify these aides were listed and without abuse findings. **Identification of Others:** The SDC has reviewed the files of current CNA's for registration and/or documentation to show the state nurse aide registry was checked to verify listing without abuse findings. CNA's whose files were not compliant had their files corrected to meet the standard. **Systemic Changes:** The SDC was educated on the State Nurse Aide Requirements for the hiring of CNA's by the DON.	6/10/15 TB

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

Admin 5/21/15

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 5/28/15. No Changes Required

DOC = 6/10/15 Verified w/ Tony James NHA

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 04/30/2015

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 225	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on employee file review, and staff interview, the facility failed to ensure the nurse aide abuse registry was checked prior to employment for 5 of 6 CNAs (#1, #2, #3, #4, #5) reviewed. The findings were: Review of the employee files for CNAs #1, #2, #3, #4 and #5 revealed there was no documentation to show the state nurse aide registry was checked to verify these CNAs were listed and without abuse findings. Interview with the staff development nurse on 4/29/15 at 4:31 PM verified the state nurse aide registry had not been checked for these CNAs. Review of the registry showed CNAs #1, #2, #3, #4, #5 had not been	F 225	The SDC or designee will ensure that new CNA's will be registered on the State Nurse Aide Registry site prior to hire. The SDC or designee will check the State Nurse Aide Registry for potential CNA candidates and obtain documentation to show the state nurse aide registry was checked to verify listing without abuse findings prior to job offering. **Monitoring:** The DON or designee will audit newly hired CNA's file for evidence of State Nurse Aide Registry documentation for two months for compliance then 2 random files thereafter until 100% compliance has been achieved for two consecutive months. Noncompliant files will be corrected immediately and other actions made where necessary. The results of the audit will be presented to the monthly QAPI meeting for review and corrective actions taken where necessary.	

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 04/30/2015

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 225	Continued From page 2 registered and therefore there was nothing in the registry related to these CNAs. The non-registered CNAs were hired within the past four months with the exception of CNA #2 who had been employed longer.	F 225	**F 241: DIGNITY AND RESPECT OF INDIVIDUALITY** It is the practice of the facility to promote care for residents in a manner and in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Corrective Action** The facial hair was removed for resident #58 by nursing staff. Her care plan has been amended to reflect the preferred method of facial hair removal. The facial hair was removed for resident #38 by nursing staff. Incontinence management has been evaluated for resident #66 and care plan and RCS task list updated to reflect needs. Resident #72 was discharged from the facility on 5/15/2015 **Identification of Others** An observation audit of residents will be completed by Director of Nursing or designee by 6/3/2015 to identify any additional residents who have unwanted facial hair or wet clothing. The audit will include observation of	6/10/15
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and medical record review, during random observations the facility failed to promote dignity for 1 sample resident (#38) and 3 non-sample residents (#58, #66, #72). The findings were: 1. Review of the 4/30/15 quarterly MDS assessment showed resident #58 had diagnoses that included dementia, and required extensive assistance with dressing and personal hygiene. Observation on 4/30/15 at 12 PM showed the resident sitting at the dining room table. The resident had noticeable whiskers on her chin and upper lip. Interview with CNA #1 on 4/30/15 at 2:45 PM revealed the resident preferred the whiskers to be plucked instead of shaved. She further revealed that it had been "about a month" since the resident's whiskers had been shaved, and that it takes a long time to pluck them out. Interview with the resident at 2:50 PM that date verified s/he doesn't like to be shaved and prefers	F 241		

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 04/30/2015

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 241	Continued From page 3 the whiskers to be plucked because when they are shaved, the hairs grow back thicker. 2. Review of the 10/2/14 annual MDS assessment showed resident #38 had diagnoses that included dementia and depression, and needed extensive assistance with dressing, personal hygiene and bathing. Observation on 4/28/15 at 11:35 AM showed the resident in his/her wheelchair outside the dining room. The resident had long facial whiskers. Observation on 4/28/15 at 1 PM, and on 4/30/15 at 2:35 PM showed the resident continued to have have whiskers. Interview on 4/30/15 at 2:35 PM with the resident revealed s/he was concerned about the whiskers and stated "I'm trying to pull them out." 3. Review of the 3/16/15 quarterly MDS assessment showed resident #66 had a diagnosis of dementia and was cognitively impaired with a brief interview for mental status (BIMS) of 0/15. Further review showed the resident required extensive assistance for dressing, toilet use, personal hygiene and bathing. Observation on 4/29/15 from 8:15 PM-8:40 PM showed the resident was awake and wandering the hallways of the secure unit. The resident was noted to be wearing pants that had two large wet areas on the back side and down the back of the legs. At 8:40 PM, 25 minutes later, the resident was provided the needed assistance by occupational therapist #1. 3. Observation on 4/28/15 at 10:45 AM showed several residents were seated at a dining table in the secure unit. The other tables in the area were noted to be dirty with visible crumbs and food debris from the breakfast meal. At 10:50 AM	F 241	dining room on secure unit for cleanliness of tables. For any residents identified with unwanted facial hair or wet clothing care plans and task list will be reviewed and updated as needed to reflect resident needs. Corrective action will be taken as needed for any identified concerns. **Systemic Changes:** Staff will be educated by Staff Development Coordinator or designee by 6/10/2015 regarding maintaining dignity by providing a clean environment in the dining room and cleaning tables timely after meals. The education will also include removing unwanted facial hair with bathing and more often if needed and assisting with incontinence management in a timely manner. **Monitoring:** Random audits will be conducted by Director of Nursing / designee for timely cleaning of dining room tables on secured unit after meals, presence of unwanted facial hair and incontinence management. The audits will be completed 3 times a week x 4 weeks, then weekly for two months. Corrective action will be taken as needed.	

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 04/30/2015

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 241	Continued From page 4 resident #72 was provided a snack by CNA #2 and the resident sat at one of the tables. As the resident sat eating the snack s/he was overheard commenting aloud how the table was "dirty" and the resident was observed brushing away the crumbs with their hand. At 11:15 AM resident #72 was observed wetting paper towels in the handwashing sink and then wiped down all of the tables in the dining room.	F 241	The Director of Nursing or designee will track and trend the results of the dignity audits and report findings to the QAPI committee. 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 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure social services were provided to maintain the highest psychosocial well-being for 1 of 17 sample residents (#11). The findings were: Review of the 3/19/15 admission MDS assessment showed resident #11 was admitted to the facility on 3/12/15 after hospital care for a stroke. Further review showed the resident had limited functional ability on the left side, cognitive impairment, no behaviors, short term memory problems, and mild depression. Review of the care plan, updated 4/6/15, showed s/he was wheelchair dependent and required assistance with most activities of daily living. The following concerns were identified:	F 250	**F 250: PROVISION OF MEDICALLY RELATED SOCIAL SERVICES** **Corrective Actions:** Resident #11 has had his/her social services assessment updated to better reflect their psychosocial needs to include family history, education background, work history, quality of life, resident's rights, marital status, lifestyle preferences, support systems and place of birth and added to the resident's MR. **Identification of Others:** The Social Services Director or designee has reviewed the social services assessments of current residents for accuracy and completeness including family history, education background, work history,	6/10/15

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 04/30/2015

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 250	Continued From page 5 1. Periodic observations from 4/28/15 through 4/30/15 revealed the resident sat in his/her room changing the channels on the television. Observations of the resident's room revealed there were no individualized and personal items in the room. During an interview on 4/28/15 at 12:15 PM, when asked about his/her room, s/he stated, "I guess it is like home, but not really." 2. Review of the 3/19/15 social services assessment and history showed the sections for documenting family history, education background, work history, quality of life, resident's rights, marital status, and place of birth were blank. Further review showed medication for depression was prescribed by the physician and memory issues could be related to the stroke. This review showed no information about family or friends. 3. Interview on 4/29/15 at 8:45 AM with the social services director revealed it was difficult for staff to determine whether the resident's self isolation was related to depression and/or the stroke or if this was the usual behavior prior to the stroke. The social services director stated an assessment regarding the resident's lifestyle, preferences, family/friend support systems, work history, and personal information would be helpful in making that determination. He further stated this information should have been obtained, documented, and shared with all staff, but it had not been done. 4. Review of the medical record on 4/30/15 showed there was no evidence of efforts to obtain this information during the 7 weeks the resident resided at the facility.	F 250	quality of life, resident's rights, marital status, lifestyle preferences, support systems and place of birth and added to the resident. Those assessments not in compliance have been updated and placed in the resident's MR. **Systemic Changes:** The Social Services Director or designee will obtain family history, education background, work history, quality of life, resident's rights, marital status, lifestyle preferences, support systems and place of birth of newly admitted and/or readmitted residents in a timely manner and placed in the resident's MR. The social services assessment will be reviewed and updated on a quarterly basis or as necessary to maintain the resident's psychosocial needs. **Monitoring:** The IDT team will review the social services assessments of newly admitted or readmitted residents for compliance three times per week for one month then three random admission assessments per month for three months. Noncompliant assessments will be corrected timely by the SSD and/or designee. Results of the review will be submitted to the monthly QAPI committee for review and corrective actions taken where necessary.	

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 04/30/2015

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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure resident areas were well maintained in 6 of 6 hallways (Hallway 100, Hallway 200, Hallway 300, Hallway 400, Hallway 500, Hallway 600). The findings were: Observation on 4/30/15 from 9:10 AM through 10:50 AM identified the following concerns with floors: a. The bathroom floor of room #107 had a darkened 20-inch crack to the right of the toilet which created an uncleanable surface. b. The bathroom floor of room #212 had a darkened 5-inch crack to the left of the toilet which created an uncleanable surface. c. Two floor tiles at the front of the floor of room #203 were cracked 3-inches across and were blackened due to an uncleanable surface. d. The bathroom floor of room #204 had a darkened 36-inch crack to the left of the toilet which created an uncleanable surface. e. The bathroom floor of room #209 had a darkened 18-inch crack to the right of the toilet which created an uncleanable surface. f. The bathroom floor of room #208 had a darkened 20-inch crack to the right of the toilet which created an uncleanable surface. In addition, the dividing strip between the bathroom floor and bedroom floor was damaged with a missing 3-inch area which created an	F 253	**F 253: HOUSEKEEPING AND MAINTENANCE SERVICES** **Corrective Actions:** The bathroom floors in rooms #107, #212, #203, #204, #209, #208, #206, #311, #304, #306, #513, and #501 have been repaired and/or replaced. The heat vent in the 600 hallway shower room has been repaired as well as the damaged door frame. The door frame in the 500 hallway shower room has been repaired. The bathroom door frames in rooms #104 and #105 have been repaired. The missing door knob on the right door cabinet across from the dining area in the 500 hallway has been replaced. **Identification of Others:** The Facility Maintenance Director has done a facility wide survey of the bathroom floors and door frames. Those areas which have an area with an unclean able surface will be reported to the Administrator and a plan developed to repair and/or replace the surfaces.	6/10/15

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 04/30/2015

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 253	Continued From page 7 uncleanable surface. g. The bathroom floor of room #206 had a darkened 21-inch crack to the left of the toilet by the wall which created an uncleanable surface. h. The bathroom floor of room #311 had a darkened 32-inch crack to the left of the toilet which created an uncleanable surface. i. The bathroom floor of room #304 had a darkened 36-inch crack to the left of the toilet which created an uncleanable surface. j. The bathroom floor of room #306 had a darkened 36-inch crack to the left of the toilet which created an uncleanable surface. k. The bathroom floor of room #513 had a darkened 11-inch crack to the right of the toilet which created an uncleanable surface. l. The floor in room 501 had 1 tile damaged near the back of the room with a 2-inch chip which created a darkened and uncleanable surface. 2. Observation on 4/30/15 from 9:10 AM through 10:50 AM identified the following concerns with shower rooms: a. The heat vent by the toilet in the shower room across from room #600 had a 13-inch by 2.5-inch area that was rusted. Also, the door frame leaving the shower room had damage from the floor to 15-inches up that included holes in the metal, which was darkened and created an uncleanable surface. b. The shower room on the 500 hallway had damage to the door frame on the right side going out with chips in the frame from the floor to 28-inches up that created an uncleanable surface. 3. Observation on 4/30/15 from 9:10 AM through 10:50 AM identified the following miscellaneous	F 253	**Systemic Changes:** The Facility Maintenance Director and/or designee will round weekly and note areas which have unclean able surfaces. Any areas found to not have cleanable surfaces will be reported to the Administrator and a plan to repair and/or replace the surface will be developed in a timely manner **Monitoring:** The Facility Maintenance Director will present a report of the progress of the repair and/or replacement of areas with uncleanable surfaces and any newly discovered uncleanable surfaces to the monthly QAPI committee meeting for review, planning, and corrective actions.	

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 04/30/2015

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 253	Continued From page 8 concerns: a. The bathroom door frame in room #104 was scraped from the floor to 14-inches up which created an uncleanable surface. b. The front doorframe to room #105 was loose from the wall from the floor to 16-inches up. c. The back wall in room #310 had damaged scraped areas into the plaster at 13-inches above the floor and 13-inches by 36-inches across. d. The right door cabinet across from the dining area in the 500 Hallway had the doorknob missing, which exposed a hole to the inside. e. Interview with the maintenance director on 4/30/15 at 11:30 AM confirmed the issues identified with the floors, shower rooms, walls, and door frames. At that time he confirmed the facility had no plan with a timeframe to complete these repairs.	F 253		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive assessment for 1 of 17 sample residents (#36) was completed within 14 calendar days after admission. The findings were:	F 273	**F 273 COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT** **Corrective Action:** Resident #36 Admission MDS was completed 4/29/15. **Identification of Others:** Newly admitted residents over the past 60 days will be audited for timely completion of Admission MDS assessments. **Systemic Changes** Newly Admitted residents will be reviewed in the morning business meeting Monday through Friday for	5/10/15

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 04/30/2015

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 273	Continued From page 9 Medical record review showed resident #36 was admitted on 4/9/15 with diagnoses that included Alzheimer's disease. Review of the medical record showed the admission MDS assessment was completed on 4/29/15, 20 days after admission, 6 days after it was due. Interview with the MDS coordinator on 4/30/15 at 2 PM confirmed the MDS assessment was late because she was "behind" on many of the assessments, and the Medicare Part A MDS assessments were a priority.	F 273	assessment needs and ARD review with the Interdisciplinary Team. The Interdisciplinary Team will have assessment timeliness review per RAI Guidelines by DDCM/Designee on or before 6/10/2015. Admission Assessments will be completed (including CAA's) within 14 days of admission as of 6/10/2015. RCMD/Designee will review admission assessments for completion and timeliness weekly for four weeks then monthly for three months.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	**Monitoring:** Results of the RCMD admission assessment review will be reported to the monthly QAPI committee meeting for review and corrective actions taken where necessary. **F 280: RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** It is the practice of the facility to strive to ensure that the resident has the right to participate in planning care and treatment or changes in care and treatment. **Corrective Action:** Resident #64 has been evaluated by therapy for assistance with meals and adaptive equipment at meal time. The plan of care has been updated to reflect recommendations.	6/10/15

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 04/30/2015

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 280	Continued From page 10 by: Based on observation, staff interview, medical record review, and review of the diet card information, the facility failed to ensure the care plan was updated to reflect the current nutritional approaches for 1 random non-sample resident (#64). The findings were: Review of the quarterly MDS assessment dated 1/9/15 revealed resident #64 had diagnoses including Alzheimer's disease, macular degeneration, and oropharyngeal dysphagia. Further review showed the resident required supervision with eating. Review of the resident's meal card revealed "Regular- Pureed" with "dark colored bowl/ plate with high sides." The following concerns were identified: a. Observation on 4/28/15 at 12:10 PM showed LPN #1 assisted resident #64 with eating. Further observation revealed the resident's food was pureed, with mashed potatoes, meat, and vegetables layered in a single white bowl. b. Observation on 4/30/15 at 11:30 AM showed cook #1 used a single white bowl to serve the meal consisting of puree rice, and puree stir fry with beef and vegetables. Interview at that time with the cook revealed she was told to serve this resident's meals in a single bowl, but was unsure why. c. Interview with the Registered Dietitian (RD) on 4/29/15 at 2:40 PM revealed he did not know exactly why the resident's food was provided in a single bowl. He confirmed that the care plan did not reflect the resident's current dining abilities and needs. Additional interview with the RD on 4/30/15 at 4:45 PM revealed the interdisciplinary team periodically reviewed residents with change in eating status to determine possible interventions. He verified this intervention was not	F 280	**Identification of Others:** An observation audit of residents who need assistance with meals or use adaptive equipment at meals will be completed by therapy director or designee to determine if current interventions are effective and reflected in plan of care. For any identified concerns corrective action will be taken. An audit of dietary tray cards will be completed by the Dietary Manager or designee to determine if adaptive equipment is indicated per care plan. Tray cards will be updated as needed based on findings. **Systemic Changes:** The Staff Development Coordinator or designee will educate licensed nurses and interdisciplinary team on updating care plans to reflect resident's needs for assistance with meals and adaptive equipment at meals. The Dietary Manager or designee will educate dietary staff on reading tray cards and providing adaptive equipment at meals as indicated. **Monitoring:** A random audit of 10 care plans per week for assistance with meals and adaptive equipment will be completed	

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 04/30/2015

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 280	Continued From page 11 documented on the care plan. d. Review of the ADL care plan showed it was last reviewed on 3/12/15 and the resident "feeds self with fingers, does not allow staff to assist with eating at times." The Nutrition care plan last reviewed on 3/12/15 showed the resident ate pureed foods and used a plate with high sides. Additionally the care plan showed finger foods were provided as needed.	F 280	weekly for ninety days on current residents by the Director of Nursing or designee for 3 months. The audit will include dining observations to determine if the plan of care reflects resident's current needs. Corrective actions will be taken as needed for based on audit findings. A random audit of 10 tray cards per week for adaptive equipment that is needed with meals will be completed by the Dietary Manager for ninety days. The audit will include observation of whether correct adaptive equipment is provided with meal service. Corrective actions will be taken as needed based on findings. The Director of Nursing will track and trend the results of the care plan 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. The Dietary Manager will track and trend the results of tray card and observation audits of adaptive equipment at meals and report findings to QAPI committee monthly. The	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to follow the care plan for 2 of 17 sample residents (#14, #76), and 1 non-sample resident (#60) in regards to providing oral care and toileting assistance. The findings were: 1. Review of the 2/24/15 quarterly MDS assessment showed resident #60 had diagnoses that included depression and dementia, and needed extensive assistance with dressing and bathing, as well as limited assistance with personal hygiene. Review of the care plan for ADLs showed it was last dated on 1/22/15 and the resident required "assist" with brushing his/her teeth daily. Observation on 4/29/15 at 8:15 PM showed CNA #3 and RN #1 provided bedtime cares. During this observation, the staff failed to	F 282		

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 04/30/2015

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 282	Continued From page 12 offer or assist the resident with performing oral care. 2. Review of the 1/22/15 quarterly MDS assessment showed resident #76 had diagnoses that included Alzheimer's disease and depression, and needed extensive assistance with dressing and personal hygiene. Review of the care plan for ADLs showed it was last dated on 3/15/15 and the resident required limited to extensive assistance from staff to complete ADLs. The interventions were for staff to provide needed supplies, encourage participation in tasks, and to provide cueing as needed. These approaches were shown to aid in meeting the goals of washing face and hands, brushing teeth and brushing hair daily. Observation on 4/29/15 at 8:30 PM showed CNA #3 and OT #1 provided bedtime cares. During this observation, the staff failed to offer or assist the resident with performing oral care. 3. Review of the 1/24/15 quarterly MDS assessment showed resident #14 had cognitive impairment and a wheelchair was the primary mobility device. Review of the MDS also showed the resident had frequent episodes of bowel incontinence and required staff assistance with toileting. Review of the 2/6/15 care plan showed staff were directed to provide toileting assistance before and after meals, at bedtime and when necessary. Continuous observations on 4/28/15 from 12:05 PM until 3:25 PM revealed the resident sat in the wheelchair in the lobby after eating lunch. At 3:30 PM, LPN #1 and CNA #4 assisted the resident to the bathroom and removed the fecal soiled disposable brief. Interview with RN #2 on 4/30/15 at 3 PM revealed staff should follow the care plan and assist the	F 282	QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance. **F 282: SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** It is the practice of the facility that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** Resident #60's plan of care for ADL's, including oral hygiene will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #60 will be educated on her plan of care for ADL's, including oral hygiene. Resident #76's plan of care for ADL's, including oral hygiene will be reviewed and updated as needed by the Director of Nursing or designee.	6/10/15

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 04/30/2015

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 282	Continued From page 13 resident to the toilet after meals because the resident did not know when s/he needed to go to the bathroom.	F 282	Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #76 will be educated on her plan of care for ADL's, including oral hygiene. Resident #14's plan of care for incontinence will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #14 will be educated on her plan of care for incontinence. **Identification of Others:** An observation audit will completed by Director of Nursing or designee to determine if care plan interventions for oral care and incontinence meet residents current needs and if care plan interventions are followed. Corrective action will be taken as needed for any identified concerns. **Systemic Changes:** The Staff Development Coordinator or designee will educate nursing staff on following interventions in care plans for oral care and incontinence.	
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to ensure the discharge summary included a recapitulation of the residents' stay for 2 of 2 closed records reviewed with anticipated discharge (#98, #99). The findings were: 1. Review of the closed medical record showed resident #98 was discharged to an assisted living facility on 3/26/15. Further review of the medical record showed no evidence of a discharge summary, including a recapitulation of the resident's stay. 2. Review of the closed medical record showed resident #99 was discharged to home on 12/13/14. Further review of the medical record showed no evidence of a discharge summary, including a recapitulation of the resident's stay.	F 283		

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 04/30/2015

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 283	Continued From page 14 3. Interview with the DON on 4/29/15 at 11:05 AM revealed if a discharge summary was completed for these residents it would have been in the record. 4. Review of the facility's policy titled "Transfer and Discharge Procedure" dated June 2013, showed the procedure for discharges included "5. Physician completed Physician Discharge Summary that provides a brief summary of the course of the resident's stay at the facility."	F 283	The RCS assignment sheets will be brought to morning interdisciplinary meeting, care conferences and weekly risk management meetings by the Director of Nursing or designee and updated as care plan is updated. Changes in care plans that affect care provided by RCS's will be reviewed with RCS's at daily "Huddle" as needed. **Monitoring:**	
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 by: Based on observation, medical record review, and staff interview the facility failed to ensure 1 of 7 residents (#14) with incontinent care needs received this care in a timely manner. The findings were: Review of the 1/24/15 quarterly MDS assessment showed resident #14 had cognitive impairment and a wheelchair was the primary mobility device. Review of the MDS also showed the resident had frequent episodes of bowel incontinence and required staff assistance with toileting. Review of the 2/6/15 care plan showed staff were directed	F 309	A random visual observation audit of 10 residents per week will be conducted by the Director of Nursing or designee for ninety days to determine if care planned interventions for oral care and incontinence are being followed. Corrective actions will be taken as needed for based on audit findings. The Director of Nursing will track and trend the results of the adherence to care plan 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.	

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 04/30/2015

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 309	Continued From page 15 to provide toileting assistance before and after meals, at bedtime and when necessary. The following concerns were identified: a. Continuous observations on 4/28/15 from 12:05 PM until 3:25 PM revealed the resident sat in the wheelchair in the lobby after eating lunch. At 3:30 PM, LPN #2 and CNA #4 assisted the resident to the bathroom and removed the fecal soiled disposable brief. b. Observation of CNA #4 who was assigned the resident's care for the day revealed she was responding to the care needs of other residents on 4/28/15 from 12:05 PM until 3:30 PM. Interview with LPN #2 on 4/28/15 at 3:30 PM revealed the facility did not have a system for tracking the time toileting assistance was provided. She further stated it was difficult for staff, other than the person responsible for the resident's care, to know the time the resident last received toileting assistance without some type of system for tracking this. c. Interview with RN #2 on 4/30/15 at 3 PM revealed staff should follow the care plan and assist the resident to the toilet after meals because the resident did not know when s/he needed to go to the bathroom.	F 309	**F 283: ANTICIPATE DISCHARGE RECAP STAY/FINAL STATUS** It is the practice of the facility to complete a discharge summary that includes a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge. **Corrective Action:** The facility is unable to correct the deficient practice for resident #98 as this is a closed record and resident has been discharged since 3/26/15. The facility is unable to correct the deficient practice for resident #99 as this is a closed record and resident has been discharged since 12/13/14. **Identification of Others:** An audit of medical records of residents discharged since 5/1/15 will be completed by Health Information Manager or designee to determine if discharge summary / recapitulation of resident stay was completed. The discharge summary / recapitulation of stay will be completed as needed. **Systemic Changes:** Licensed nurse and interdisciplinary team will be educated by Staff Development Coordinator or designee	6/10/15
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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 04/30/2015

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 441	Continued From page 30 performing hand hygiene the CNA placed the tabs alarm on the resident, pushed the lift into the hallway, moved the resident's wheelchair, placed the fall mat at the resident's bedside, and then washed her hands. Continued observation showed the lift was not cleaned and was in the hallway available for use. 3. Interview with the infection preventionist on 4/30/15 at 10:15 AM revealed her expectation was the staff should remove their gloves after performing perineal care, prior to completing additional cares for the residents. 4. Observation on 4/28/15 at 5:08 PM showed resident #3 used his/her utensils to retrieve ice from the communal ice pitcher at the dining table. RN #4 watched this happen, told the resident "I could have gotten you ice," but did not replace the contaminated ice pitcher. Continued observation at 5:35 PM showed the contaminated ice pitcher was still present on the table. At this time CNA #6 served food to a resident at the table. Resident #51 used his/her utensils to retrieve ice from the same communal ice pitcher. CNA #6 watched the resident serve him/herself ice, but did not replace the contaminated ice pitcher. Continued observation until 5:50 PM showed the contaminated ice pitcher remained at the resident's table, and all four residents served themselves water and ice from the pitcher.	F 441	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 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.	

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 04/30/2015

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 312	Continued From page 16 Based on observation, medical record review and staff and resident interview, the facility failed to ensure 2 of 17 sample residents (#38, #76) and 2 non-sample residents (#58, #60) who were dependant on staff were provided the necessary care. The findings were: 1. Review of the 2/24/15 quarterly MDS assessment showed resident #60 had diagnoses that included depression and dementia, and needed extensive assistance with dressing and bathing, as well as limited assistance with personal hygiene. Review of the care plan for ADLs showed it was last dated on 1/22/15 and the resident required "assist" with brushing his/her teeth daily. Observation on 4/29/15 at 8:15 PM showed CNA #3 and RN #1 provided bedtime cares. During this observation, the staff failed to offer or assist the resident with performing oral care. 2. Review of the 1/22/15 quarterly MDS assessment showed resident #76 had diagnoses that included Alzheimer's disease and depression, and needed extensive assistance with dressing and personal hygiene. Review of the care plan for ADLs showed it was last dated on 3/15/15 and the resident required limited to extensive assistance from staff to complete ADLs. The interventions were for staff to provide needed supplies, encourage participation in tasks, and to provide cueing as needed. These approaches were shown to aid in meeting the goals of washing face and hands, brushing teeth and brushing hair daily. Observation on 4/29/15 at 8:30 PM showed CNA #3 and occupational therapist #1 provided bedtime cares. During this observation, the staff failed to offer or assist the resident with performing oral care.	F 312	on completion of discharge summary and recapitulation of resident stay upon discharge. Pending and actual discharges will be reviewed daily in morning clinical meeting and the Health Information Manager or designee will place needed discharge paper work, including discharge summary / recapitulation of stay in medical record for completion. **Monitoring:** Medical records for discharged residents will be audited by Heath Information Manager or designee after discharge for completion of discharge summary /recapitulation of stay The audits will be completed weekly for ninety days.. Corrective action will be taken as needed. The Director of Nursing or designee will track and trend the results of the discharge summary audits and report findings to the QAPI committee. 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.	

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 04/30/2015

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 312	Continued From page 17 3. Interview with RN #3 on 4/30/15 at 10 AM verified the expectation was for CNAs to provide assistance with oral care in the mornings and before the resident goes to bed at night. 4. Review of the 10/2/14 annual MDS assessment showed resident #38 had diagnoses that included dementia and depression, and needed extensive assistance with dressing, personal hygiene and bathing. Observation on 4/28/15 at 11:35 AM showed the resident in his/her wheelchair outside the dining room. The resident had noticeable long whiskers. Observation on 4/28/15 at 1 PM, and on 4/30/15 at 2:35 PM showed the resident continued to have the long whiskers. Interview on 4/30/15 at 2:35 PM with the resident revealed s/he was concerned about the facial hairs and stated "I'm trying to pull them out." 5. Review of the 4/30/15 quarterly MDS assessment showed resident #58 had diagnoses that included dementia, and required extensive assistance with dressing and personal hygiene. Observation on 4/30/15 at 12:00 PM showed the resident sitting at the dining room table. The resident had noticeable whiskers on her chin and upper lip. Interview with CNA #1 on 4/30/15 at 2:45 PM revealed that the resident preferred the whiskers to be plucked instead of shaved. She further revealed that it had been "about a month" since the resident's whiskers had been shaved, and that it takes a long time to pluck them out.	F 312	**F 309: PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** It is the practice of the facility that each resident receive and the facility provides 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. **Corrective Action:** Resident #14's plan of care for incontinence will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #14 will be educated on her plan of care for incontinence. **Identification of Others:** An observation audit will be completed by Director of Nursing or designee to determine if care plan interventions for incontinence meet residents current needs and if care plan interventions are followed. Corrective action will be taken as needed for any identified concerns.	6/10/15
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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 04/30/2015

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 323	Continued From page 18 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure adequate supervision for 2 sample residents (#25, #36) and 2 non-sample residents (#72, #94) identified with behaviors. In addition, the facility failed to ensure water temperatures were at safe levels in random rooms on 6 of 6 hallways (100 Hallway, 200 Hallway, 300 Hallway, 400 Hallway, 500 Hallway, 600 Hallway). The findings were: The following concerns were identified with supervision of residents with behaviors: 1. Review of the 3/19/15 admission MDS assessment showed resident #72 had a brief interview for mental status (BIMS) score of 3/15, had diagnoses that included bi-polar and post-traumatic stress disorder, and needed extensive assistance with ADLs. Review of the 3/19/15 care plan related to "individual preferences" showed the resident "thinks [s/he] is at work and puts on synthetic gloves." The approaches included "Honor individual choices and preferences as able within parameters of facility and other individuals safety and choices or preferences." The resident care plan failed to address any additional behaviors that may affect other residents. The following concerns were	F 323	**Systemic Changes:** The Staff Development Coordinator or designee will educate nursing staff on following interventions in care plans for incontinence. The RCS assignment sheets will be brought to morning interdisciplinary meeting, care conferences and weekly risk management meetings by the Director of Nursing or designee and updated as care plan is updated. Changes in care plans that affect care provided by RCS's will be reviewed with RCS's at daily "Huddle" as needed. **Monitoring:** A random visual observation audit of 10 residents per week will be conducted by the Director of Nursing or designee for ninety days to determine if care planned interventions for incontinence are being followed. Corrective actions will be taken as needed for based on audit findings. The Director of Nursing will track and trend the results of the adherence to care plan 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	

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 04/30/2015

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 323	Continued From page 19 noted: a. Observation on 4/29/15 at 8:45 PM showed the resident stopped resident #78 in the hallway by placing his/her hands on the walker of resident #72. RN #1 was offering a cup of pills to resident #78, and resident #72 took the medications from the nurse and tried to offer them to the other resident. During this observation, the nurse did not attempt to verbally or physically stop resident #72 from handling the medications, which dropped on the floor. b. Interview at the time with the nurse revealed she allowed the resident to "help" because s/he was once an employee at the facility. c. Interview with the DON and administrator on 4/30/15 at 12:40 PM revealed the resident attempted to frequently "help" other residents. 2. Review of the 1/29/15 admission MDS assessment showed resident #25 had a BIMS score of 9/15, had diagnoses that included dementia and depression, and needed moderate assistance with ADL's. Review of the nursing notes from February 2015 showed the resident was involved in 4 resident to resident altercations. The nursing notes dated 2/2/15 timed at 6 PM showed the resident had an altercation with his/her roommate. Review of the nursing notes dated 2/4/15 timed at 7:50 PM showed the resident had another altercation with his/her roommate. The nursing notes dated 2/5/15 timed at 3:30 PM showed the family was contacted about the altercation and discovered the resident was discharged from a different nursing home due to previous behaviors, and had stayed at a specialized facility previously. The nursing notes dated 2/8/15 timed 3 PM showed the resident had another altercation with his/her roommate that	F 323	months and then reassess the need for continued monitoring based on compliance. **F 312: ADL CARE PROVIDED FOR DEPENDENT RESIDENTS** It is the practice of the facility that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **Corrective Action:** Resident #60's plan of care for ADL's, including oral hygiene will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #60 will be educated on her plan of care for ADL's, including oral hygiene. Resident #76's plan of care for ADL's, including oral hygiene will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the RCS assignment sheets will be updated to reflect current needs. Staff who are routinely assigned to care for resident #76 will be educated on her plan of	6/10/15

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 04/30/2015

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 323	Continued From page 20 required staff intervention. The nursing note dated 2/9/15, untimed, showed the resident was "afraid someone was coming in to hit [resident]...and someone was hiding in closet." Review of the nursing note dated 2/10/15, untimed, showed "Res. was yelling at another res. the slapped [him/her] on the rt [right] cheek as res. was trying to pass by in w/c [wheelchair] and accidentaly [sic] bump res walker." The following concerns were noted: a. Observation on 4/28/15 at 12:10 PM showed the resident was in the dining room, and there were no staff present at that time. The resident assisted his/her table mates with pouring water from a pitcher. At 12:15 PM resident #25 began forcing his/her table mate (#7) to drink from a cup of water. Resident #7 was trying to stop resident #25 from placing the water cup in his/her face, by batting away resident #25. At 12:16 PM Unit Manager #1 walked into the dining room and intervened. Review of the nursing notes on 4/29/15 showed no evidence of this altercation. b. Observation on 4/28/15 at 5:01 PM showed the resident was in the dining room, and there were no staff present at that time. At 5:02 PM resident #94 poured his/herself water from a pitcher, which spilled onto the table cloth. Resident #94 was using his/her butter knife to push the water onto the floor, and resident #25 told him/her to use the napkin. Resident #94 did not use a napkin, and continued to use the butter knife to push the water onto the floor. Resident #25 stood up and attempted to wrestle the knife away from resident #94. State survey agency staff alerted RN #4 who then intervened. Review of the nursing notes on 4/29/15 showed no evidence of this altercation. c. Interview with the DON and administrator	F 323	care for ADL's, including oral hygiene. The facial hair was removed for resident #58 by nursing staff. Her care plan has been amended to reflect the preferred method of facial hair removal. The facial hair was removed for resident #38 by nursing staff. **Identification of Others:** An observation audit of residents will be completed by Director of Nursing or designee to identify any additional residents who have unwanted facial hair or are in need of oral care. For any residents identified with unwanted facial hair or needing oral care the care plans and task list will be reviewed and updated as needed to reflect resident needs. Corrective action will be taken as needed for any identified concerns. **Systemic Changes:** Staff will be educated by Staff Development Coordinator or designee regarding providing assistance with ADL's including removing unwanted facial hair and providing assistance with oral care in accordance with plan of care. The education will include removing unwanted facial hair with bathing and more often if needed.	

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 04/30/2015

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 323	Continued From page 21 on 4/30/15 at 12:30 PM revealed the resident's table mates had not been assessed for their own safety. 3. Review of the 4/29/15 admission MDS assessment showed resident #36 had diagnoses that included Alzheimer's disease, had physical and verbal behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing) 1 to 3 days during the 7 day "look back" period which put other residents at significant risk for physical injury, intruded on the privacy of others, significantly disrupted the living environment, and needed extensive assistance with ADLs. Review of the 4/29/15 care plan showed "Individual Preferences" included interventions of "Honor individual choices and preferences as able within parameters of facility and other individuals safety and choices or preferences." Review of the nursing notes from April 2015 showed the resident was involved in an altercation with another resident. The nursing note dated 4/23/15 timed 6 PM showed the resident "was observed in confrontation c [with] peer. They were grabbing & slapping @ [at] each other...conts [continues] to get into trash cans & tear up paper into shreads [sic]." The following concerns were noted: a. Confidential interview with 11 residents on 4/29/15 at 1 PM showed each was concerned regarding the behavior of resident #36. One resident stated s/he was "afraid" of the resident. b. Interview with resident #22 on 4/28/15 at 8:55 AM and 4/30/15 at 5 PM revealed resident #36 comes into his/her room uninvited and this makes him/her "uncomfortable." The resident then stated resident #36 "steals," and "throws stuff at me." Resident #22 stated s/he had reported this to staff, however, the situation	F 323	The RCS assignment sheets will be brought to morning interdisciplinary meeting, care conferences and weekly risk management meetings by the Director of Nursing or designee and updated as care plan is updated. Changes in care plans that affect care provided by RCS's will be reviewed with RCS's at daily "Huddle" as needed. **Monitoring:** A random visual observation audit of 10 residents per week will be conducted by the Director of Nursing or designee for ninety days to determine if care planned interventions for oral care and removal of unwanted facial hair are being followed. Corrective actions will be taken as needed for based on audit findings. The Director of Nursing will track and trend the results of the adherence to ADL 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.	

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 04/30/2015

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 323	Continued From page 22 continued. According to resident #22, two unwanted visits happened on 4/29/15. c. Interview with CNA #5 on 4/30/15 at 4:50 PM revealed resident #36 had "situations" with others. The aide further revealed the unwanted situations happened on a "daily basis" and are usually a result of the resident's "impatience with others." The following concerns were identified related to environmental safety: Observation on 4/29/15 from 3:40 PM through 5:15 PM revealed the following water temperatures which were at an unsafe temperatures ranging between 116 to 124 degrees Fahrenheit (F): a. When measured, the sink water temperature in room #101 was 124 degrees F. b. The sink water temperature in room #301 was 122 degrees F. c. The sink water temperature in room #209 was 122 degrees F. d. The sink water temperature in room #309 was 122 degrees F. e. The sink water temperature in room #105 was 120 degrees F. f. The sink water temperature in room #206 was 120 degrees F. g. The sink water temperature in room #212 was 118 degrees F. h. The sink water temperature in room #410 was 118 degrees F. i. The sink water temperature in room #103 was 118 degrees F. j. The sink water temperature in room #411 was 116 degrees F. k. In the secure unit shower room the shower water temperature was 118 degrees F, the tub	F 323	**F 323: FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **Corrective Actions:** Resident #72 has been discharged to home with family. Resident # 25 has been assigned to a table with table mates who have been assessed to be able to manage their own safety. Their care plan has been updated to reflect these changes and added to their MR. Resident #36 has been given a number of items which he/she can use for cognitive stimulation to keep he/she from wandering and intruding on other resident's space. Their care plan has been updated to reflect these changes and added to their MR. Rooms # 301, #209, #309, #105, #206, #212, #410, #103, #411, and the secured unit shower room have had their water temperature adjusted to consistently be below 110 degrees F. **Identification of Others:** The Facility Maintenance Director has checked the temperature of the water in the facility to ensure they are in compliance. Water faucets not in compliance were made so immediately.	6/10/15

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 04/30/2015

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 323	Continued From page 23 water temperature was 118 degrees F. During an interview on 4/29/15 at 5:25 PM with the maintenance director, he confirmed the water available for residents in the facility had unsafe temperatures by using the facility thermometer to re-test the water previously tested by the surveyor. He further confirmed the facility failed to monitor water temperatures for water available to residents.	F 323	The facility Social Services Director and/or designee have interviewed cognitive residents regarding any other residents whom they may feel unsafe around or are fearful of. No other residents were mentioned. **Systemic Changes:** Current staff was educated on techniques in redirection of residents who can become disruptive or display behaviors that affect other residents. The Facility Maintenance Director has read the CMS and State of Wyoming regulations on water temperature control and the requirements for regular testing and documentation of the hot water. The Facility Maintenance Director will take a sample of hot water temperatures weekly for one month then monthly thereafter per CMS and facility protocol. The DON or designee will review the 24 hour report and Incident and Accident reports for residents who have displayed disruptive or invasive behaviors 4 times per week. Immediate interventions and care plan updates will be completed when necessary. An IDT meeting involving residents with behaviors will be conducted	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that – (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical	F 334		

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 04/30/2015

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 334	Continued From page 24 contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	weekly to address residents who display disruptive or invasive behaviors and interventions put in place where necessary. **Monitoring:** The Facility Maintenance Director will submit a report on the hot water temperatures to the monthly Safety Committee with the minutes presented to the monthly QAPI committee meeting for review and corrective actions where necessary. The IDT will present a monthly status report on behaviors to the monthly QAPI committee for review and corrective actions where necessary. **F 334: INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS** **Corrective Actions:** Residents # 35, #42, #61, and #76 and/or their legal guardian have been given educational information regarding the influenza and pneumococcal immunizations and their immunization record updated to reflect whether they received the immunizations. **Identification of Others:** The Infection Control Nurse has reviewed the immunization records for documentation of education regarding	6/16/15

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 04/30/2015

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 334	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to implement a system for ensuring influenza and pneumococcal immunizations were offered or provided for 4 of 5 sample residents (#35, #42, #61, #76) selected for comprehensive review. The findings were: 1. Review of the medical record and October 2014 to March 2015 medication administration records for residents #35, #42, #61, #76 revealed no evidence the residents or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the residents either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Review of the two most current MDS assessments for the four residents showed the immunization section was marked but it was unclear whether the immunizations were administered and/or when this occurred. 2. According to the policy and procedures for Resident Care Polices, revised 2012, staff should document the administration of the vaccine, including injection site, in the medical record or staff/volunteer immunization record. 3. Interview with the Infection Control Nurse on 4/30/15 at 10:45 AM revealed the facility did not have a system for monitoring which residents received immunizations and for ensuring education was provided. She further stated due to the lack of documentation about residents who did or did not receive the immunizations; she was	F 334	influenza and pneumococcal immunizations for current residents and whether the immunizations were administered. Those residents found to not have documentation will receive the educational information and have their immunization record updated and added to their MR. **Systemic Changes:** The Infection Control Nurse has read the CMS regulations regarding Influenza and Pneumococcal immunizations requirements including documentation and education. The Infection Control Nurse or designee will maintain annual immunization records per CMS and facility policy and update the resident's MR where necessary to reflect their immunizations. The Infection Control Nurse or designee will review newly admitted residents for record of pneumococcal and influenza immunizations. Residents without an updated record will be corrected by the Infection Control Nurse or Designee to accurately reflect their immunization history. **Monitoring:** The Director of Nursing or designee will audit 3 newly admitted resident charts per week for one month then 3	

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 04/30/2015

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 334	Continued From page 26 unsure which of the current residents, including residents #35, #42, #61, and #76 were provided immunizations and the required education.	F 334	charts monthly for 2 months for an updated and accurate immunization record and documentation of education regarding Influenza and/or Pneumococcal vaccinations when applicable. Those charts that are not compliant will be corrected timely. The results of the audits will be presented to the monthly Infection Control Meeting and the minutes presented to the monthly QAPI committee meeting for review and corrective actions where necessary.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure the residents were offered a bedtime snack daily. The facility census was 96. The findings were: 1. Confidential interview with 11 residents on 4/29/15 at 1 PM revealed bedtime snacks were not always offered to residents. 2. Observation on 4/29/15 from 8:05 PM to 9 PM revealed 8 residents were in the common	F 368	**F 368: FREQUENCY OF MEALS/SNACKS AT BEDTIME** It is the practice of the facility that each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community and to offer a snack at bedtime daily. **Corrective Action:** No residents were identified. **Identification of Others:** All facility residents have the potential to be affected by not offering HS snacks. **Systemic Changes:** Nursing and dietary staff will be educated by Staff Development	6/15/15

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 04/30/2015

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 441	Continued From page 28 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an infection control program that maintained a sanitary environment in regards to shared food and perineal care, for 1 mealtime observation and 2 of 3 perineal care observations, which affected residents #3, #51, #60, and #76. The findings were: 1. Review of the 1/22/15 quarterly MDS assessment showed resident #60 had diagnoses that included Alzheimer's disease, and needed extensive assistance with dressing, personal hygiene, and toileting. The following concerns	F 441	comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action:** Resident # 60's room, equipment, call bed have been cleaned, bed linen changed since the observation by surveyor on 4/29/15. Education with return demonstration was completed with the employees involved. Resident # 76's room, equipment, call bed have been cleaned, bed linen changed since the observation by surveyor on 4/29/15. Education with return demonstration was completed with the employees involved. Water pitchers were removed from all dining room tables on 4/28/15 and washed. **Identification of Others:** All residents in the dining rooms have the potential to be affected by water pitcher cross contamination. Skills checks for hand washing, glove use, cross contamination with perineal care will be completed with nursing staff to identify any concerns. Corrective action will be taken as needed.	

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 04/30/2015

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 441	Continued From page 29 were noted: Observation on 4/29/15 at 8:12 PM showed RN #1 and CNA #3 assisted the resident to bed. During this observation, CNA #3 performed perineal care with gloved hands, placed the new brief on the resident, and then used soiled gloves to assist the resident by lowering him/her to the bed with the use of the sit-to-stand lift. She touched the sling and the lift, and then touched the resident's hair and face, and raised the bedding for the resident. The CNA placed the resident's fall mat at the bedside, lowered the bed, placed the tabs alarm on the resident's clothing and bed, placed the call light in reach, and then washed her hands. During this observation the lift was not cleaned. The CNA then pushed the sit-to-stand lift into the hallway. Continued observation until 8:30 PM showed the lift was not cleaned before use with resident #76. 2. Review of the 2/24/15 quarterly MDS assessment showed resident #76 needed extensive assistance with dressing and toileting. The following concerns were noted: Observation on 4/29/15 at 8:30 PM showed CNA #3 and occupational therapist #1 assisted the resident to bed. During this observation CNA #3 performed perineal care with gloved hands, then used a disposable wipe to remove bowel movement from her gloves, did not remove her gloves, and then used the soiled gloves to assist the resident to bed. She placed a new brief on the resident, touched the resident, used the sit-to-stand lift controls to lower the resident to the bed, removed the sling and the leg strap, touched the resident's hand, placed the bedding on the resident, and then removed her gloves. Without	F 441	**Systemic Changes:** The Staff Development Coordinator or designee will educate nursing staff on infection prevention precautions, including when to wash hands, gloving, and cross contamination. New employees will be educated during orientation period and validated with skills observation. New water pitchers, which have lids have been purchased by the Dietary Manager for dining room tables. **Monitoring:** The Staff Development Coordinator or designee will complete random audit 3 times weekly for one month and then weekly for two months of residents receiving perineal care. The audit will include visual observation of staff performance of care, including hand washing, gloving and cross contamination. Corrective actions will be taken as needed for any identified concerns. The Dietary Manager or designee will complete a random audit 3 times weekly for 1 month and then weekly thereafter for two months of sanitation practices related to ice water on dining room tables. Corrective action will be taken for any identified concerns.	