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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535024	A. Building B. Wing	3/4/2015

Name of Facility	Street Address, City, State, Zip Code
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 03/04/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 03/04/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TB 4/30/15	Date:	Signature of Surveyor: Linda Brown TB	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/6/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

POC accepted 3/31/15

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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 _____	R-C PP 03/04/2015

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{F 000}	INITIAL COMMENTS This survey was conducted in conjunction with seven new complaints and a revisit to the December 11, 2014 and January 6, 2015 complaint surveys. The seven new complaints investigated were: WY00001977, WY00001985, WY00001989, WY00001990, WY00001993, WY00001995 and WY00001997. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	{F 000}		
{F 309} SS=D	483.26 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 resident and staff interview, observation, medical record review, standards of nursing practice, and facility policy review, the	{F 309}	**F-309: Provide Care and Service for Highest Well Being** The facility strives to ensure that each resident receives and is provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	4/2/15 PC

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

1 Admin 4/2/15

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.

RECEIVED
WY Dept of Health
MAY 14 2015
Healthcare Licensing and Surveys

3/31/15 @ 2pm POC accepted per telephone call with administrator, Tony Jarvis. P. Purvis

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

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{F 309}	Continued From page 2 2. Review of the 2/24/15 quarterly MDS assessment showed resident #12 had severe cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 with personal hygiene. Review of the February 2015 recapitulation of physician orders showed the resident had diagnoses including dementia and resided in the secure dementia unit. On 3/2/15 at 12:50 PM the resident stated s/he was "wet". Interview with CNA #2 at that time revealed the "resident probably does [did] need changed because [s/he's] been having diarrhea since yesterday" (3/1/15). The following concerns were identified: a. Review of the 24 hour nursing reports for each day from 2/23/15 through 3/3/15 showed no evidence the resident's signs and symptoms, including diarrhea, were identified by nursing staff. b. Review of the nursing notes showed no evidence an assessment of the resident was performed. Further review of the nursing notes showed the last entry was dated 2/24/15 at 1 AM. Review of the vitals signs flow sheet showed the last set of vital signs recorded were on 2/20/15. c. Interview with the DON on 3/4/15 at 10:10 AM revealed nurses did not document assessments in the nursing notes; they documented them on SBAR forms. However, review of the SBAR (Situation Background Assessment Request) form used to document assessments in change of condition showed it was also dated 3/3/15, 2 days after signs and symptoms were identified. 3. According to "Nursing Interventions & Clinical Skills", 5th Edition, 2012, by Perry, Potter, and Elkin, page 113, "Nurses perform systematic assessments on a regular basis in nearly every	{F 309}	**Systemic Changes** The Director of Nursing or designee will educate nurses on evaluating change of condition, documenting in medical record, documentation on 24 hour report, physician and family notification, developing care plans for those with infections. The 24 hour report, new telephone orders and new physician orders will be reviewed at morning interdisciplinary team meeting by Director of Nursing or designee. Documentation of nurse's evaluation, notifications and care plans will be checked at meeting to determine if a change of condition, including infections is addressed. **Monitoring** A random audit of 10 residents with change of condition will be completed weekly by Director of Nursing or designee for 30 days and then monthly for 2 months. The audit will include documentation of evaluation, notifications and care plan. Corrective actions will be taken as needed based on findings.	

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{F 309}	Continued From page 3 health care setting...In nursing homes..when a patient's health status changes". Review of the facility's policy on "Change of Condition", revised June 2008, showed the change of condition form should be used to assess and document changes in condition....provide clear comprehensive documentation."	{F 309}	The Director of Nursing or designee will track and trend the results of the change of condition audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	
{F 353} SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, family, resident and staff interview, staffing schedules and assignment sheets, and the resident census report, the facility	{F 353}	**F-353: SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLAN** The facility strives to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, psychosocial well-being of each resident, as determined by resident assessment and individual plan of care. **Corrective Actions** A new bladder evaluation will be completed for resident #11 by 3/21/15 by Director of Nursing or designee. After completion of the bladder evaluation the care plan for	4/21/15

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{F 353}	Continued From page 4 failed to consistently ensure 5 of 5 nursing units were sufficiently staffed to meet the needs of residents. The findings were: 1. Review of the quarterly MDS assessment dated 2/9/15 showed resident #11 had moderate cognitive impairment, was frequently incontinent of bowel and bladder, and required extensive assistance of 2 with toileting and personal hygiene. Observation on 3/2/15 at 1:35 PM showed the resident resided in the secure dementia unit. Observation on 3/2/15 from 1:35 PM through 6:05 PM showed the resident was in bed. Observation at 1:52 PM showed CNA #2 entered the resident's room but provided no personal care. Interview with the resident at 6:05 PM revealed s/he had been sick with diarrhea all day. The resident asked to have his/her shirt changed because it was wet and s/he needed help. The CNA (#2), who was in the hallway at the time, was informed of the resident's request for assistance. Interview with the CNA at the time revealed the resident had been in bed all day with diarrhea and she immediately went in to change the resident's shirt. While changing the shirt the bed was observed to have a large, approximately 18 inches by 20 inches, area where urine had soaked through the resident's slacks and incontinence brief onto the sheet. The CNA changed the bedding. Review of the 11/17/14 care plan showed the resident should be toileted before and after meals, upon waking, at bedtime and as needed. Continuous observation from 1:52 PM to 6:05 PM showed the resident was not toileted or offered toileting for 4 hours and 13 minutes. 2. Interview with the DON on 3/4/15 at 10:10 AM, and verified by the administrator in an interview	{F 353}	incontinence will be reviewed and updated as needed. Resident #11's task list will be reviewed and updated as needed to reflect incontinence management interventions. Education will be completed with nursing staff that routinely provide care to resident # 11 on incontinence management interventions per care plan. **Identification of others** The Administrator and DON reviewed nursing staff schedules beginning on 3/19/15 through 4/30/2015 for sufficient nursing staff to provide nursing and related cares to the residents in accordance with their care plans. **Systemic Changes** The Staffing Coordinator or designee will contact available staff to make arrangements to provide sufficient nursing staff on days where necessary. The Administrator, DON, and Staffing Coordinator will review staffing levels 3 to 5 times per week to discuss any actions needed to provide sufficient nursing staff based on current census and care plan needs.	

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{F 353}	Continued From page 5 on 3/17/15 at 4 PM, revealed the routine shifts were 7 AM to 7 PM and 7 PM to 7 AM for nursing staff. For CNAs the shift hours were 6 AM to 6 PM and 6 PM to 6 AM with a few 4 and 8 hour shifts for staff who were unable to work the 12 hour shifts. 3. Based on review of the facility's census, there were 103 residents in-house on 2/24/15. Review of the staff time sheets for 2/24/15 provided by the facility on 3/16/15 showed during the night shift there were 3 RNs in the building to pass medications, provide treatments, and perform assessments as needed. An additional RN who worked the day shift stayed over into the night shift until 9:10 PM. There were 2 CNAs to care for 103 residents, 20 of whom were in a separate locked dementia unit. There was 1 CNA who worked the day shift who did not leave her shift until 6:41 PM (41 minutes into the night shift). Finally, there were 2 RAs (resident assistants) who also worked from 6 PM to 11 PM and 1 RA who worked from 6 PM to 6 AM. However, review of the facility job description for an RA showed an RA was not qualified to provide personal care for residents. Their duties included keeping resident rooms neat and orderly, making beds, filling water pitchers, pushing wheelchairs, and answering call lights to let a resident know the RA would locate a CNA or nurse to assist him or her. The ratio of CNAs to residents was 1 to 51 during the night shift. 4. Based on review of the facility's census, there were 102 residents in-house on 2/25/15. Review of the staff time sheets for 2/25/15 provided by the facility on 3/16/15 showed during the night shift there was 1 RN in the building to pass medications, provide treatments, and perform	{F 353}	The Administrator, DON and Staffing Coordinator will conduct 1 to 2 staffing calls with Corporate Level Managers to discuss employee retention, recruitment, and staffing levels. **Monitoring** The Director of Nursing or designee will audit 5 resident's care plan task lists 3 times per week for completeness (to include a minimum of 1 in the Secured Care Unit) to gauge sufficient staffing to provide nursing and other cares were completed per the resident's Care Plan for two weeks then 3 resident's care plan task lists (1 in the SCU) per week after that. The Customer Service Director or designee will conduct random interviews with interview able residents weekly for 4 weeks and then monthly for 2 months to find out if their needs are being met in a timely manner. The results of the audits will be presented to the QAPI monthly meeting for review and corrective actions where necessary.	

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(F 353)	Continued From page 6 assessments as needed from 7 PM to 7 AM. An additional RN who worked the day shift stayed over into the night shift until 9 PM. There was 1 CNA who worked the entire night shift to care for 102 residents, 20 of whom were in a separate locked dementia unit. An additional CNA worked from 10 PM to midnight. One CNA from the day shift worked until 6:30 PM, an extra 30 minutes. Finally, there was 1 RA who worked from 6 PM to 6 AM and 2 RAs who worked from 6 PM to 10:30 PM. One RA worked from 1 PM to 10 PM as well (4 hours into the night shift). Again, RAs were not qualified to provide personal care for residents. The ratio of CNAs to residents on the night shift was 1 to 102. The ratio of RNs to residents during the night shift was 1 to 102. 5. Based on review of the facility's census, there were 104 residents in-house on 2/26/15. Review of the staff time sheets for 2/26/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 7 AM. There were 2 day shift RNs who worked over into the night shift; one until 9 PM and one until 7:30 PM. Continued review showed only 1 CNA worked the night shift from 6 PM to 7 AM to provide personal care for 104 residents, 20 of whom were in a locked dementia unit. One day shift CNA stayed until 6:30 PM and another CNA worked from 4:30 PM to 1 AM. One RA worked the entire night shift, one worked from 1 PM to 9:15 PM, and one worked from 6 PM to 7 PM. The ratio of CNAs to residents was 1 to 104 during most of the night shift from 1 AM to 6 AM. 6. Based on review of the facility's census, there were 104 residents in-house on 2/27/15. Review	(F 353)		

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{F 353}	Continued From page 7 of the staff time sheets for 2/27/15 provided by the facility on 3/16/15 showed during the night shift there was 1 RN and 1 LPN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 7 AM. There were 3 CNAs on the night shift to care for 104 residents, 20 of whom resided in a locked dementia unit. In addition, one CNA worked from 5:30 PM to 1 AM, one from 6 PM to 10 PM, and one who worked until 7 PM. One RA worked from 1:45 PM to 8:41 PM. The ratio of CNAs to residents was 1 CNA to 34 residents after 1 AM. 7. Based on review of the facility's census, there were 103 residents in-house on 2/28/15. Review of the staff time sheets for 2/28/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs and 1 LPN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 8 AM. In addition, 1 day shift RN worked until 7:30 PM, 30 minutes beyond the end of the shift. There were 4 CNAs who worked the night shift for a ratio of 1 CNA to 26 residents. Two day shift CNAs worked over until 7 PM. No RAs worked during that night shift. 8. Based on review of the facility's census, there were 101 residents in-house on 3/1/15. Review of the staff time sheets for 3/1/15 provided by the facility on 3/16/15 showed during the night shift there were 2 RNs and 1 LPN in the building to pass medications, provide treatments, and perform assessments as needed from 7 PM to 8 AM. In addition, 1 day shift RN worked 1 hour and 12 minutes beyond her shift and another worked an additional 2 hours into the night shift. There were 4 CNAs who worked the night shift for a ratio of 1 CNA to 25 residents. One CNA worked	{F 353}		

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(F 353)	Continued From page 8 from 5 PM to 10:44 PM, one worked from 10 PM to 7 AM and there was 1 RA who worked from 6 PM to 6 AM. 9. Interview with 2 CNAs, #1 and #7 on 3/1/15 at 10 PM revealed there was almost always only 1 CNA for the night shift in the secure unit and 1 for the remainder of the halls. Both stated staffing had been and continued to be a "huge" issue. 10. Interview with a family member on 3/2/15 at 12:30 PM revealed the facility was short staffed. She said "I think they need more help." The family member verified there was only 1 CNA in the secure unit and 1 CNA on the halls outside the secure unit on the night shift; that was when incontinence care was not provided in a timely manner. She said the CNAs worked very hard and provided the best care possible based on the number of staff available. 11. On 3/1/15 from 10:30 PM until 10:45 PM, CNA #3, CNA #6, CNA #4 and LPN #1 were interviewed individually regarding staffing. All stated there was insufficient staff on the second 12 hour shift and the lack of staff resulted in delayed response to call lights, delayed meal service, lack of monitoring for falls and the inability to provide toileting assistance timely. One CNA stated the supervisors and administrative staff came in or remained on duty to help at times, but not every time. The interview with the LPN revealed the licensed nurses had to postpone passing medications and assist the CNAs with resident care when there was insufficient staff on duty. The staff schedule for 2/24/15 to 3/1/15 was reviewed with the DON on 3/3/15 at 6:55 PM. At that time the DON stated staffing with CNAs continued to be a challenge,	(F 353)		