POC accepted 8/8/07 Jackie Cole-DPH

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 SS=E	483.16(a) DIGNITY 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, resident and staff interview, and review of posted meal times and resident council minutes, the facility failed to respect each resident's dignity by serving meals in a timely manner in two of four dining areas. The findings were: 1. Observation on 7/9/07 at 5:38 PM revealed a plate of food for non-sample resident #62 was on a table in the main dining room. The resident was propelling himself/herself in a wheelchair in the dining room, heading towards the table. Volunteer #1 stopped the resident, and said, "you already ate." The volunteer took off the clothing protector and pushed the resident out of the dining room and into the hallway. At 5:40 PM, certified nurse aide (CNA) #1, who was seated at the table, summoned CNA #2. He told CNA #2 that the resident was mistakenly taken from the dining room, and the resident should be brought back in order to eat. CNA #2 left the dining room to get the resident, but returned without him/her. The CNA (#@) stated that the resident did not want the food now. Interview on 7/11/07 at 4:50 PM with the administrator and director of nursing (DON) revealed they felt this situation would require some training with the volunteers. 2. Review of the posted meal times for the secure unit showed breakfast was served daily from 6:30	F 241	Corrective action was attempted by C.N.A#2. Any resident eating in the dining room could be affected by the inappropriate action of the volunteer. Volunteers will be inserviced as to proper behaviors while assisting residents in the dining room by the SDC Perceived inappropriate actions by a volunteer will be taken to QA&A for review and recommendations. Daily random audits of time elapsed between preference of meal served and the time the meal was served will be done. DNS/designee Results of the audits will be presented to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months. Dining room tables in SCU are used for activities as well as meals. SCU caregivers will be inserviced to seat residents at a table for an activity until meal service starts. SDC Random daily audits of appropriate activities being present prior to meals will be done. Results will be presented to QA&A for recommendations,times 3 months.	8-26-07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lillian W Johnson — TITLE: NHA — (X6) DATE: 8-3-07

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.

Changes made per phone call RECEIVED: NHA, on 8/8/07 @ 9:10 Am. Jackie Cole-DPH

AUG 16 2007

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

8/8/07

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4303 S POPLAR ST 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 1	F 241		

AM to 9 AM. Observation of the morning meal on 7/10/07 revealed the following concerns:

a. At 6:40 AM resident #89 was seated at the dining table. At 7:55 AM (1 hour and 15 minutes later) the resident was served breakfast.

b. At 7:06 AM resident #27 was seated at the table drinking coffee. The resident was served his/her breakfast meal 54 minutes later at 8 AM.

c. Interview with the dietary manager on 7/10/07 at 9:50 AM revealed breakfast was late that morning because they were "short of staff" in the unit.

3. Review of the posted meal times in the secure unit showed the evening meal service was scheduled to begin at 4:30 PM. Observation in the unit on 7/9/07 at 5:00 PM showed resident #6 seated in a wheelchair in the dining room with his/her head on the table. Continuous observation showed the resident remained in that position until his/her meal was served at 5:35 PM (35 minutes later).

4. During a confidential interview on 7/10/07 at 2:30 PM, six residents said it was not unusual to have to wait from 30 minutes to an hour for breakfast and lunch to be served. The residents stated this problem was due to "organization and communication problems."

Review of the 6/18/07 resident council minutes revealed this concern had been raised during the meeting and recorded in the minutes as: "... dining room unorganized - waiting about one hr [hour] before being served after the time it is to be served."

Interview with the dietary manager on 7/11/07 at 4:40 PM revealed she was aware of the resident's comments during the 6/18/07 resident council meeting. The dietary manager

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 2 stated the facility had been taking various actions over the last year to correct this problem.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE 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 walls were free of gouges and chipped paint in two of four resident lounge areas. In addition, the facility failed to ensure the vinyl was repaired to a chair used by resident #89. The findings were: Observation of the physical environment and interview with the maintenance director on 7/12/07 at 8:15 AM revealed two walls in the secure unit sun room were gouged and had paint missing. Each wall had an area approximately six feet long of noticeable damage. In addition, the resident lounge area, where the bird cage was located, had two walls that were gouged, as well as missing paint. At this time the maintenance director stated he was aware the walls needed paint. He also stated interior painting was only done once a year, and it was scheduled to be done in the fall. Observation on 7/10/07 at 9:30 AM revealed resident #89 used a wheeled recliner. Both arms of the chair had missing and torn vinyl on the outer edges. On 7/12/07 at 8:15 AM the maintenance director stated he was aware the arms were damaged. He stated three months prior he had switched the arms of the chair around so the tears were on the outside. He	F 253	No residents were affected by the physical environmental issues. Corporate approved painting schedule will be utilized to assure facility has painting/repair work done timely. Areas cited will be painted. 8-26-07 An audit of repair work and time schedule for completion will be done by M.D. Resident #89 recliner is a personal chair. POA notified of need for new arms. New arms will be placed by M.D. Inservice of staff to report any areas of needed painting/repair will be conducted by	

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 3 stated the torn areas needed further repair.	F 253	SDC.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, and staff interview, the facility failed to	F 272	Audit and time schedule will be presented to QA&A monthly for recommendations and action. 8-26-07	

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 272	Continued From page 4 complete a comprehensive assessment of all needed areas for 1 (#65) of 22 sample residents. The findings were: Review of admission orders dated 5/22/07 showed resident #65 had an order for 25mg of Vistaril (antianxiety medication) at 11 PM, for sleep. Review of the medication administration records (MARs) showed the resident received the Vistaril from 5/22/07 through 5/31/07, 6/1/07 through 6/4/07, and 6/8/07 through 6/11/07. On 6/11/07 the pharmacist recommended to the physician that the Vistaril be discontinued and that an order be written for 5mg of Ambien (sedative-hypnotic) to be administered at bedtime "as needed". The physician subsequently ordered Ambien 5 mg at bedtime as needed for sleep. Review of the MARs showed the resident received the Ambien 15 times from 6/14/07 through 6/30/07, and every night 7/1/07 through 7/10/07. During an interview on 7/11/07 at 1:20 PM, the resident stated he/she does not sleep well. The resident stated his/her usual sleep pattern at home was 11 PM to 5 AM, but in the facility the resident was only sleeping about 3 or 4 hours. Review of the medical record revealed no evidence that a comprehensive sleep assessment had been completed in order to determine the resident's usual sleep pattern/disturbance and to identify any possible reasons for insomnia, such as noise, pain, side effects of medication, stress, depression, etc. On 7/12/07 at 8:25 AM, the director of nursing (DON) looked through the medical record and verified there had been no comprehensive sleep assessment.	F 272	No residents were affected by the lack of a sleep study. A sleep study was done on resident #65 by ADON on 7-24-07. A sleep assessment will be completed on all residents who receive a medication for insomnia. All residents who receive a medication for sleep will have their sleep pattern monitored by utilizing the psychoactive medication flow sheet. 1. In-service all licensed nurses as to the monitoring of residents who utilize medication for sleep and on how to complete the sleep assessment form. 2. Random review of all residents who receive a medication for sleep will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months.	8-26-07
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED	F 273		

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 5	F 273		

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 complete comprehensive assessments within 14 calendar days from admission for 2 (#6, #54) of 22 sample residents. The findings were:

1. Review of the medical record face sheet showed resident #54 was admitted on 4/16/07. Review of the admission Minimum Data Set (MDS) assessment showed the assessment reference date was 4/26/07. However, the date the registered nurse signed the assessment as complete was 6/11/07. Interview with the director of nursing on 7/12/07 at 8:40 AM confirmed the admission assessment was completed late.
2. According to the medical record face sheet, resident #6 was admitted to the facility on 4/19/07. On 4/24/07 a nursing note documented the resident was transferred to the hospital. Review of physician's orders showed the resident was readmitted on 5/2/07. The following concerns were noted with the timeliness of the admission MDS assessment:
a. Review of the admission MDS assessment showed it was completed on 5/25/07 (37 days from the first admission and 24 days from the date of readmission).

Review of residents shows none were affected by the late assessments.

A second fulltime Registered Nurse will start assisting with MDS Assessments on 8-13-07.

Comparison of CMS resident roster and facility tickler system will be done monthly by RCMD.

Weekly audits of completions reports will be done by RCMD.

A review of any residents with late assessment will be done in the morning department head meeting by NHA.

Results of the weekly completion audits will be presented to QA&A meeting for recommendations and action until assessments are all timely plus 3 months. 8/26 /07

PRINTED: 07/27/2007
FORM APPROVED
OMB NO. 0938-0391

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

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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 6	F 273		

b. Interview with the director of nursing on 7/11/07 at 1:45 PM confirmed the assessment was late.

According to the Centers for Medicare and Medicaid Services, Revised Long-Term Care Facility Resident Assessment User's Manual, Revised March 2007, page 2-4, "If a resident goes to the hospital and returns during the 14-day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. In this case, the Assessment Reference Date remains the same and the Admission comprehensive assessment must be completed by day 14 counting from the original date of admission. Otherwise the assessment should be reinstated with a new Assessment Reference Date and completed within 14 days after readmission from the hospital."

F 281 SS=D 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based observation, medical record review and staff interview, the facility failed to follow physician's orders for 2 (#6, #95) of 19 sample residents who resided in the facility at the time of the survey. The findings were:

1. Medical record review of resident #95 on 3/9/07 revealed a physician's order for bilateral

F 281 Residents #95 was assisted to put on her bilateral knee high hose.

An audit for any other resident with orders for knee high hose will be conducted. DNS/designee

Random audits of placement of knees high hose will be conducted daily by DNS/designee.

Resident #6 was weighed.

An audit for any resident to be weighed 2x week was conducted by DNS/designee.

Random weekly audits of resident who are to be weighed 2x week will be conducted.

Random review of weekly weights and the audit of residents who wear compression stockings will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months. 8/26/07

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

PRINTED: 07/27/2007
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
	535034	A. BUILDING _____ B. WING _____	C 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 281	Continued From page 7 knee high graduated compression hose except when the resident was sleeping in bed. The care plan for the problem of peripheral edema revealed the resident was to wear compression stockings as ordered. Observation of the resident on 7/10/07 at 10 AM and 4 PM revealed the resident was not wearing the compression hose. Interview with licensed practical nurse (LPN) #1 on 7/11/07 at 3 PM revealed the resident could independently dress him/herself, except for the compression hose. According to this interview the resident required assistance from staff to put on the compression stockings. The nurse stated the resident was not wearing the compression hose, because they could not find the particular pair of hose the ones the resident preferred. 2. Record review for resident #8 revealed a 5/21/07 "Report of Consultation" that included a physician's order to weigh the resident two times a week due to recent severe weight loss. Review of the "Vital Sign & Weight Flow Sheet" showed weekly weights from 5/22/07 through 7/3/07. Interview with the director of nursing on 7/11/07 at 4:45 PM confirmed twice weekly weights had not been obtained as ordered by the physician. 3. According to the State of Wyoming Nursing Practice Act of July 2005 and the Administrative Rules and Regulations of November 2003, pages 3-8, nursing must function under the direction of a licensed physician.	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	6306 S POPLAR ST 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 8	F 282		

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to assure care was provided in accordance with the written plan of care for 2 (#64, #89) of 19 sample residents who resided in the facility at the time of the survey. The findings were:

1. Review of the 6/21/07 care plan showed staff were to reposition resident #64 every two hours and toilet the resident before and after meals. However, observation on 7/10/07 from 1 PM until 6:10 PM (5 hours 10 minutes) revealed the resident was in a wheelchair and was not repositioned. In addition, the resident was not taken to the bathroom during the entire observation, which exceeded 5 hours. At 6:10 PM, the surveyor informed the director of nursing (DON) that the resident had not been toileted, and the DON asked a certified nurse aide (CNA) to take the resident to the toilet. CNA #3 took the resident to the bathroom, and stated the resident's brief, pants and stockings were all wet and had to be changed.

2. Observation on 7/10/07 from 6:40 AM to 9:30 AM (2 hours, 50 minutes) revealed resident #89 was seated in a wheelchair. During the observation, the resident was not repositioned. According to the 4/4/07 quarterly Minimum Data Set (MDS) assessment, the resident was totally dependent on staff for all activities of daily living. Review of the 4/1/07 care plan showed the resident was also at risk for pressure ulcers, and was to be repositioned every two hours while in the chair. Interview with the director of nursing on 7/12/07 at 8:45 AM confirmed the care plan was

Resident #64 and #89 were repositioned.
Refer to F 315 for toileting for resident #64.
Residents who need to be repositioned could be affected by lack of repositioning.

An inservice for caregivers on policy and procedures of repositioning will be given by SDC. Random daily audit of repositioning of residents needing assistance will be completed. See F 315 for toileting 8/26/07
Results of the random repositioning audit will be presented to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months.

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 9 to be followed, and the resident should have been repositioned sooner.	F 282		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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: Based on observation, medical record review, and staff interview, the facility failed to ensure assistance for 1 (#84) of 8 sample residents who required assistance with dining. The findings were: Review of the 6/6/07 quarterly Minimum Data Set assessment for resident #84 showed s/he required extensive assistance with eating. The most current care plan related to nutrition was dated 10/6/06, and showed the resident required assistance with eating. The undated certified nurse aide (CNA) cardex showed staff were to assist and supervise eating for this resident. Observation on 7/10/07 at 4:35 PM to 5:14 PM revealed that the resident was served his/her meal at 4:35 PM. Continued observation showed the resident did not make any attempt to eat or drink on his/her own. During this observation, there was no attempt by staff to assist the resident. At 5:14 PM the resident's tray was removed from the table. Review of the 7/10/07 secure unit report sheet where meal intakes were recorded showed staff had documented that the resident had refused the evening meal.	F 312	Resident #84 will receive assistance with dining. No other residents were affected by the lack of assistance with the meal. An audit will be done to identify any resident needing assistance with meal. Random daily audits will be done to identify if residents that need assistance are accommodated, by DNS/designee. Results of the dining audit will be reviewed by the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months.	8/26 /07

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 10 Interview with the director of nursing on 7/12/07 at 8:45 AM revealed this resident's functional ability varied, but that assistance should have been provided if the resident made no attempt to feed him/herself.	F 312		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide care to promote continence for 1 (#64) of 10 sample residents who were incontinent of bladder. The findings were: Review of the 6/18/07 significant change Minimum Data Set (MDS) assessment showed resident #64 was "frequently" incontinent of bladder (incontinent daily with some control). The 6/18/07 Resident Assessment Protocol (RAP) summary for incontinence documented the resident's perception of the need to empty the bladder was absent, and the resident would, therefore, be toileted both before and after meals. Review of the 6/21/07 care plan verified that staff were to toilet the resident before and after meals. However, observation on 7/10/07 from 1 PM until	F 315	Resident #~~63~~ 64 was toileted immediately. No other residents were affected by the lack of timely assistance. Caregivers will be inserviced on the policy and procedure for toileting residents who need assistance, by SDC. 8-26-07 Random daily audits will be conducted to assess timely toileting of residents that need assistance with toileting. DNS/designee Results of the random audits will be presented to the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months.	

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 315	Continued From page 11 6:10 PM (5 hours and 10 minutes) revealed that, during this elapsed time frame, the resident was not taken to the bathroom or checked for incontinence. At 6:10 PM, when the director of nursing (DON) was informed of the observation, the DON asked a certified nurse aide (CNA) to take the resident to the toilet. CNA #3 took the resident to the bathroom and, during an interview immediately following the visit to the bathroom, stated the resident's disposable brief, pants, and stockings were wet and had to be changed.	F 315	Resident #65 had a sleep assessment done. See F 272.	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	other No residents were affected by this deficient practice Review of the residents who receive a hypnotic medication for appropriateness of the medication will be conducted by Soc. Service. Results of the audit will be presented to the QA&A committee for recommendations and action x 3 months.	8-26-07

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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 329	Continued From page 12	F 329		

by:
Based on medical record review, resident interview, and staff interview, the facility failed to ensure 1 (#65) of 22 sample resident's drug regimens were free of unnecessary drugs. The findings were:

Review of admission orders dated 5/22/07 showed resident #65 has an order for 25mg of Vistaril (antianxiety medication) to be administered at 11 PM for sleep. Review of the medication administration records (MARs) showed the resident received the Vistaril from 5/22/07 through 5/31/07, 6/1/07 through 6/4/07, and 6/8/07 through 6/11/07. On 6/11/07 the pharmacist recommended to the physician that the Vistaril be discontinued and that 5 mg of Ambien (sedative-hypnotic) be ordered at bedtime as needed. The physician agreed and ordered in accordance with the recommendation of the pharmacist. Review of the MARs showed the resident actually received the Ambien 15 times from 6/14/07 through 6/30/07, and every night 7/1/07 through 7/10/07. During an interview on 7/11/07 at 1:20 PM, the resident stated he/she did not sleep well. The resident stated his/her usual pattern at home had been to sleep from approximately 11 PM to 5 AM, but since being in the facility was only sleeping about 3 or 4 hours per night. Review of the medical record revealed no evidence that a comprehensive sleep assessment was ever completed for this resident to determine his/her usual sleep pattern and possible reasons for insomnia. On 7/12/07 at 8:25 AM, the director of nursing (DON) looked through the medical record and verified that there was no comprehensive sleep assessment.

Review of the care plan, dated 6/13/07, documented that the resident had insomnia. The

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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 329	Continued From page 13 established goal was that the resident would sleep at least six hours per night. However, review of the medical record showed staff did not monitor the number of hours of sleep the resident was getting. On 7/12/07 at 8:25 AM the DON confirmed staff did not document the number of hours of sleep, therefore the facility could not determine the effectiveness of the medication. Furthermore, there lacked evidence that non-pharmacological interventions had been tried or might have been effective in assisting this resident with obtaining adequate sleep.	F 329		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and procedures, the facility failed to assure utensils were properly washed and sanitized to minimize the potential for food-borne illness. In addition, the facility failed to assure food handlers restrained their hair in an effort to minimize the potential for food contamination. The findings were: Observation on 7/9/07 at 3:35 PM revealed dietary aides #1 and #2 were washing utensils in a three-compartment sink. The following concerns were identified: a. There was no water in the first sink compartment. Interview with dietary aide #1 at that time revealed the first compartment was	F 371	No residents were affected. The dietary aid put on a hair net. An inservice and test was given to all dietary employees to assure understand ing of the policy and procedure for 1. 3 compartment sink use 2. proper clorine concentration 3. hairnet use. A random daily audit of the proper use of the 3 compartment use, clorine concentration and hairnet use will be conducted by DM.7-26-07 A poster displaying proper use of the 3 compartment sink was placed by DM 8-03-07. Results of the random audits will be presented to QA&A committee for recommdations and actions x 3 month.	8-26-07

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

PRINTED: 07/27/2007
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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR ST 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 371	Continued From page 14 used to rinse and scrape the utensils; the utensils were then soaked in a sanitizing solution in the second compartment. The third compartment was used for rinsing. b. Interview with dietary aide #1 and #2 at that time revealed dietary aide #1 was shown how to use the three-compartment sink, but he "forgot" the procedure. Dietary aide #2 commented she had never used a three-compartment sink. c. On 7/9/07 at 4 PM the dietary manager checked the concentration of the chlorine sanitizing solution with a test strip. Observation revealed the solution was in excess of 200 parts per million (ppm). d. Interview with the dietary manager on 7/11/07 at 2:30 PM confirmed that she knew the proper sequence for the three sinks was to wash, rinse, and then sanitize. Interview with the dietary manager on 7/9/07 at 4 PM verified that the concentration of the chlorine sanitizing solution should have been between 50 - 100 ppm. Review of the facility's policy and procedure titled "Warewashing by Hand" released or revised 12/06, showed the three compartment sink ware-washing method was to begin with scraping food particles from pots and pans, and pre-rinsing. Detergent was to be added to the first compartment for soaking and scrubbing, the second compartment was supposed to be for rinsing, and the third compartment was for soaking in a sanitizing solution. The policy also stated that a chlorine sanitizing solution was to be between 50 - 100 ppm. According to the ServSafe Coursebook, Third Edition, National Restaurant Association, 2004, "Cleaning and Sanitizing in a Three-Compartment Sink," page 12-11, the first	F 371	Random review of the hair net audit and compartment sink audit will be completed by the QA&A committee for recommendations and action to be taken as needed for continued compliance x3 months.	8-26-07

PRINTED: 07/27/2007
FORM APPROVED
OMB NO. 0938-0391

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

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 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 E POPLAR ST 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 371	Continued From page 15	F 371		

step is to rinse, scrape or soak all items before washing. The items are then washed in the first sink, rinsed in the second sink, and the third sink is for sanitizing. Page 12-8 documents the chlorine sanitizing solution should be 50 ppm if the water temperature is between 75 and 100 degrees Fahrenheit.

2. Observation on 7/9/07 at 3:35 PM revealed cook #1 was in the kitchen preparing food for the evening meal. Further observation revealed he was not wearing a hair restraint. Interview with the dietary manager on 7/11/07 at 2:30 PM confirmed the facility's expectation was that the cook restrain his hair.

The facility's policy and procedure titled, "Food Handling Practices" released 4/05, documented food service employees should " restrain hair appropriately."

According to the 2005 U.S. Public Health Service Food Code 2-402.11, page 46, "Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food ..."