STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

10/14/14

(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 The following common abbreviations are used throughout this document: RN- Registered Nurse CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set ADL- Activity of Daily Living mg-Milligrams mL- Milliliters mEq- Milliequivalent Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the results of the most recent State survey in an area readily accessible to residents. The census was 58. The findings were:	F 167	The facility will ensure that the resident can examine the results of the most recent survey in a place readily accessible to residents and will post notice of their availability. a. The most recent survey will be post right next to the Director of Nursing's office and posted as the most recent survey. b. The NHA or designee will move the recent survey and place on shelf. c. The residents will be told of the move of the most recent survey book during our monthly resident council meeting. d. This will be monitored on a monthly basis and brought to QAPI until resolved. The results of the monitoring will be recorded on a spreadsheet. by the DON or designee 9/4/2014 9/20/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 9/29/14

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.

10/14/14- Plan of correction accepted with changes. Kelli Rogge, Administrator notified by phone. Date of compliance 9/20/14. Jami VanDyke, RN

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F 167	Continued From page 1 Observation on 8/7/14 at 10 AM revealed State survey results were posted in the foyer of the facility. However, there was a locked door between the resident living areas and the survey results. In order to access the results, residents had to ask a staff member to unlock the door. Interview with the DON on 8/7/14 at 11 AM confirmed the survey results were not available to residents without the intervention of staff.	F 167		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	The facility will ensure that the MDS assessments accurately reflect the resident's status. 1. Resident #33 will have a corrected MDS done to ensure that the Mary Walker that is used by resident is coded as a restraint as the resident cannot exit the gait on his/her own. 2. Resident #16 will have a corrected MDS done to ensure that he/she is coded correctly as a moderate risk for developing a pressure ulcer. 3. Resident #39 will have a correct MDS done to ensure that he/she is coded correctly as being at risk for pressure ulcers.	

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F 278	Continued From page 2 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the MDS assessment was accurate for 3 of 15 sample residents (#16, #33, #39). The findings were: 1. Review of physician orders showed on 4/25/14 resident #33 was ordered a Merry Walker (enclosed wheeled walker with a seat). Review of a 4/25/14 assessment for the use of the Merry Walker showed the instructions stated the Merry Walker would be considered a restraint if the resident was unable to open the gate independently. Observation on 8/6/14 at 4:25 PM showed the resident was in the Merry Walker. At 4:40 PM CNA #1 opened the gate to the Merry Walker and assisted the resident to transfer to a dining room chair. Interview with the CNA at that time revealed the resident had the ability to get out of a regular chair, but may fall. Review of the 8/4/14 quarterly MDS assessment showed the resident did not utilize any restraints. During an interview on 8/7/14 at 10:30 AM, the MDS coordinator confirmed the resident was unable to open the gate to the Merry Walker. She stated she did not code the Merry Walker as a restraint because she felt the device was the least restrictive for the resident. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0, April 2012, "...Enclosed-frame wheeled walkers, with or without a posterior seat, or other	F 278	4. Residents #33, 16 and 39 along with all residents will have their assessments reviewed along with their most recent MDS at their quarterly care plans by the IDT. 5. DCC's MDS nurse attended the MDS boot camp in July and is working on her certification and this should help her on understanding the importance of correct coding and accurate assessments. 6. The MDS nurse or designee will monitor that the MDS assessments accurately reflect the resident's status. The monitoring tool will include comparisons to last MDS assessments. The monitoring tool will include the printed out comparisons of the MDS and monitored on a monthly basis and brought to QAPI until resolved.	9/4/14 9/20/14

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F 278	Continued From page 3 devices like it should not automatically be classified as a restraint. These types of walkers are only classified as a restraint if the resident cannot exit the gate. " 2. Review of the 7/4/14 Braden scale (assessment to measure risk of development of pressure ulcers) showed resident #16 was at moderate risk for the development of pressure ulcers. However, review of the 7/4/14 annual MDS assessment showed the resident was coded as not being at risk for the development of pressure ulcers. During an interview on 8/7/14 at 10:30 AM the MDS coordinator confirmed the MDS assessment was not accurate in regards to pressure ulcer risk. She stated she was new in the position and was still learning. 3. Review of the 7/8/14 significant change MDS assessment showed resident #39 was not at risk for pressure ulcers. However, the same assessment showed the resident had a pressure ulcer at the time of assessment. Review of the 4/1/14 quarterly assessment showed the resident had previously been assessed as being at risk of pressure ulcers. Interview with the MDS coordinator on 8/7/14 at 10:30 AM confirmed she had coded the resident's pressure ulcer risk incorrectly.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		

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F 279	Continued From page 4 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to utilize the care planning process to address all of the identified problems for 4 of 15 sample residents (#5, #27, #29, #39). The findings were: 1. Review of the 7/8/14 significant change MDS assessment showed resident #39 triggered for further assessment in areas including delirium, ADL functional/rehabilitation potential, nutritional status, pressure ulcers, and psychotropic drug use. Review of nurse charting dated 7/4/14 timed at 10:04 PM, showed the resident had an open area to the coccyx. Review of nurse charting dated 7/7/14, timed at 9:53 AM, showed the resident was weak, but able to go to the bathroom with staff assistance and using a walker. Review of section V of the same MDS assessment revealed the facility decided to proceed with care planning for these areas. However, review of the resident's care plan, last	F 279	The facility will ensure that that the results of the assessment will be used to develop, review and revise the resident's comprehensive plan of care. 1. Resident #39's care plan will reflect his/her triggers for assessments including delirium, ADL functional/rehabilitation potential, nutritional status, pressure ulcers and psychotropic drug use. 2. Resident #5 care plan will reflect his/her decline in ADL self-performance in bed mobility, off unit locomotion, dressing, personal hygiene and bathing. 3. Resident #27 care plan will reflect his/her assessments that triggered in nutritional status and communication. 4. Resident #29's care plan will reflect his/her assessments that triggered in delirium, visual function, nutritional status and pain. a. All residents will have their care plans reviewed to ensure that their care plans reflect their assessments. b. Care plans will be reviewed by the IDT team or designee on a weekly basis, and will be tracked via a spreadsheet and brought to QAPI on a monthly basis until resolved.	~~9/4/2014~~ 9/20/14

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F 279	Continued From page 5 reviewed in its entirety on 7/23/14 at an interdisciplinary care conference, showed none of these areas were addressed in the care plan. 2. Review of the 11/29/13 annual MDS assessment showed resident #5 triggered for further assessment in ADL functional/rehabilitation potential. Review of section V of the same MDS assessment revealed the facility decision to proceed with care planning for this area. Comparison with the 5/18/14 quarterly MDS assessment showed the resident had experienced a decline in ADL self-performance in bed mobility, off unit locomotion, dressing, personal hygiene and bathing. However, review of the resident's care plan, last reviewed in its entirety on 5/21/14 at an interdisciplinary care plan conference, showed this care area was not addressed in the care plan. 3. Review of the 7/15/14 annual MDS assessment for resident #27 revealed care area assessments were triggered for the following: nutritional status and communication. Review of the resident's care plan showed these 2 areas were not addressed. 4. Review of the 7/30/14 significant change MDS assessment for resident #29 revealed care area assessments were triggered for the following: delirium, visual function, nutritional status, and pain. Review of the resident's care plan showed these 4 areas were not addressed. 5. Interview with the MDS coordinator on 8/7/14 at 10:30 AM revealed care plans were developed and updated by herself with input from the interdisciplinary team. The MDS coordinator	F 279		

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F 279	Continued From page 6 further verified the above noted areas were not addressed in the care plans but should have been.	F 279		
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 ensure the care plan was followed for 1 of 13 sample residents (#9). The findings were: Review of the 12/4/13 significant change and the 5/23/14 quarterly MDS assessments showed resident #9 was coded as having highly impaired hearing. Review of the care plan, last updated on 3/3/14, showed one of the interventions to improve communication for this resident was to utilize a communication board. However, observation on 8/4/14 from 3 PM until 5:34 PM revealed the communication board was not used by the resident or staff. Observation from 8:30 AM to 11:23 AM on 8/5/14 also showed the resident did not utilize the communication board and was not encouraged to by staff. Further periodic observations on 8/6/14 and 8/7/14 revealed the communication board was not used by the resident or staff. Interview with the DON and staff development coordinator (SDC) on 8/7/14 at 9 AM revealed the communication board was kept in a drawer in the resident's room	F 282	The facility will ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care 1. Resident #9 will have his/her communication board used to help with resident's communication and understanding of direction. a. All staff will be in serviced by staff development coordinator or designee. All new staff will be in serviced of resident #9's communication board. b. All resident(s) plan of cares will be followed. Staff will be in-serviced on the importance of following resident's plan of care. c. This will be monitored by Alzheimer Unit Coordinator or designee on a random check that is done on a monthly basis and brought to QAPI until resolved.. The results of the monitoring will be recorded on a spreadsheet.	9/4/2014 9/20/14

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F 282	Continued From page 7 but should be more readily accessible for staff and others to use. Both the DON and SDC stated the communication board should be used as indicated on the care plan.	F 282		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a communication board was accessible for 1 of 1 sample residents (#9) with impaired hearing and communication. The findings were: Review of the 12/4/13 significant change and the 5/23/14 quarterly MDS assessments showed resident #9 was coded as having highly impaired hearing. Review of the care plan, last updated on 3/3/14, showed one of the interventions to improve communication for this resident was to utilize a communication board. However, observation on 8/4/14 from 3 PM until 5:34 PM revealed the communication board was not used. Observation from 8:30 AM to 11:23 AM on 8/5/14 also showed the resident did not utilize the communication board at any time. Further	F 313	The facility will ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities. 3 1. Resident #9 will have his/her communication board used when communicating with him/her. a. Staff will be in-serviced the importance of using the communication board with resident #9. All new staff will be in-serviced as they come in-to the building and start work on the Alzheimer unit. In-servicing will be done by staff development coordinator or designee. b. All residents who have assistive devices to maintain vision and hearing abilities will have them used. c. This will be monitored by Alzheimer Unit Coordinator or designee on a random check that is done on a monthly basis and brought to QAPI until resolved. The results of the monitoring will be recorded on a spreadsheet.	9/4/2014 9/20/14

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F 313	Continued From page 8 periodic observations on 8/6/14 and 8/7/14 revealed the communication board was not used by the resident or staff. Interview with the DON and staff development coordinator (SDC) on 8/7/14 at 9 AM revealed the communication board was kept in a drawer in the resident's room but should be more readily accessible for staff and others to use. Both the DON and SDC stated the communication board should be used because the resident often became uncooperative and combative when s/he did not hear what staff wanted him/her to do. They felt it might decrease the resident's behaviors if s/he knew what was happening.	F 313		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain a medication error rate of less than 5 percent (%). Two medication errors were observed out of 33 opportunities for error, which resulted in an error rate of 6.06%. Residents affected by these errors were 2 non-sample residents (#46, #56). The findings were: 1. Observation on 8/6/14 at 9:30 AM showed RN #1 gave resident #56 two tablets of calcium/magnesium/vitamin D 500/250/500 mg. Review of the 7/27/14 physician orders in the medical record revealed the resident was	F 332	The facility will ensure that we are free of medication error rates of five percent or greater. 1. Resident #56's dosage of calcium mg &D3 250/500 po BID will be given correctly. 2. Resident #46's dosage of Potassium liquid of 7.5 ml will be given correctly. 3. All residents will be given their correct dosages of medications at all times.	

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F 332	Continued From page 9 prescribed "calcium [with] mg & D3 250/500 i [1 tablet] po [by mouth] BID [twice daily]." The 2 tablets that were administered was twice the amount ordered. 2. Observation on 8/7/14 at 9 AM showed RN #1 gave resident #46 Potassium liquid 15 ml (20 mEq) in apple juice. Review of the physician orders dated 5/29/14 revealed the resident was prescribed Potassium liquid 7.5 ml (10 mEq). The resident was administered twice the amount of the medication as ordered. 3. Interview with the DON on 8/7/14 at 11 AM confirmed these medications were not given as ordered by the physician.	F 332	4. Nurses will be in-serviced the importance of reading doctor orders correctly and administering the correct dosages to residents. The in-service will be done by the staff development coordinator or designee. 5. Nurse #1 will be observed during med pass on a monthly basis by DON or designee and results will be brought to QAPI until resolved no errors are observed. The results of the observation will be recorded on a spreadsheet.	9/4/14 9/20/14
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to	F 356		

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F 356	Continued From page 10 residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total number of nursing staff and their actual hours worked in an area readily accessible to residents. The findings were: Observation on 8/4/14 at 4 PM revealed the nurse staffing and actual hours were posted in the entryway of the facility. However, there was a locked door between the resident living areas and the posting. In order to access the information, residents had to ask a staff member to unlock the door. In addition, the staffing was posted for the entire day instead of at the beginning of each shift as required. Observation on 8/7/14 at 8 AM revealed the posting remained in the same location. Interview with the DON on 8/7/14 at 9 AM confirmed the nursing staff posting was posted for the entire day instead of at the beginning of each shift. She also verified the information was not readily accessible to residents without asking for staff assistance.	F 356	The facility will ensure that we post, facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and resident census; this must be done at the beginning of each shift. 1. The nurse staffing and actual hours will be posted by DON's office to ensure easy accessibility for residents. 2. The nurse staffing will be done at the beginning of each shift not for the entire day. 3. Nursing staff will be in-serviced on the proper way of filling out the nurse staffing at each shift. In-servicing will be done staff development coordinator or designee. 4. The nurse staffing post will be monitored by DON or designee on a monthly basis and brought to QAPI until resolved. The results of the monitoring will be recorded on a spreadsheet.	9/4/14 9/20/14
F 371	483.35(i) FOOD PROCURE,	F 371		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(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 SS=E	Continued From page 11 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nutritional supplements were not expired in 3 of 3 refrigerators. The findings were: Review of instructions written on the cartons of Mighty Shakes (nutritional supplements) showed the product was good for 14 days after thawing. The following concerns were identified: 1. Observation during the initial tour on 8/4/14 from 3:15 PM until 3:31 PM revealed the following: a. 24 Mighty Shakes were partially thawed in the walk-in refrigerator in the kitchen. The shakes were not labeled with the thaw date. b. 6 thawed Mighty Shakes were in the mini-fridge in the nursing station. There lacked thaw dates. c. The mini-fridge in the secure care unit (SCU) contained 2 thawed Mighty Shakes without a thaw date. 2. Observation on 8/5/14 at 10:10 AM showed the	F 371	The facility will ensure that we procure food from sources approved or considered satisfactory by federal, state or local authorities and store, prepare, distribute and serve food under sanitary conditions. 1. All mighty shakes will be dated with a thaw date. 2. All food/drink will have the appropriated date marked. 3. The dietary manager or designee will in-service kitchen staff on putting thaw dates on mighty shakes as well as all food/drink. 4. The thaw date will be monitored on a monthly basis and brought to QAPI until resolved; the dietary manager or designee will monitor and record monitoring on a spreadsheet.	9/4/2014 9/20/14

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F 371	Continued From page 12 SCU refrigerator contained 7 thawed Mighty Shakes without a thaw date. 3. On 8/6/14 at 10:50 AM observation revealed 2 thawed Mighty Shakes in the walk-in refrigerator. The cartons were not labeled with the thaw date. 4. Observation on 8/6/14 at 2:25 PM showed 5 Mighty Shakes in the nursing station refrigerator. The cartons were not labeled with the thaw date. 5. During an interview on 8/6/14 at 2:26 PM the dietary manager stated she was not aware that Mighty Shakes were only good for 14 days after thawing. She confirmed the facility did not label the cartons with a thaw date.	F 371	The facility will ensure that the physician reviews the resident's total program of care including medications and treatments at each visit. 1. Resident #9 will have a progress note from 6/2/14 placed in medical chart. 2. All residents will have progress notes placed in their medical chart in a timely manner. 3. NHA or designee will talk to hospital and Medical Director the importance of DCC receiving progress notes in a timely manner. 4. Medical records or designee will monitor progress notes and their timeliness for our residents on a monthly basis and brought to QAPI until resolved the results will be tracked via a spreadsheet.	9/4/2014 9/20/14
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician progress notes were written and available in the medical record from the physician's visit for 1 of 13 sample residents (#9). The findings were:	F 386		

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F 386	Continued From page 13 Review of physician progress notes for resident #9 showed the resident was seen by a physician on 6/2/14; however, as of 8/7/14 there were no physician progress notes from that visit available. During an interview on 8/7/14 at 11:05 AM, the DON and LPN #1 stated the facility was aware there were problems with obtaining physician written progress notes in a timely manner.	F 386		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the resident was seen by a physician at least every 60 days for 5 of 13 sample residents (#8, #16, #27, #29, #38). The findings were: 1. Review of physician progress notes for resident #16 showed the resident was seen by a physician on 12/12/13 and then 3/6/14 (84 days between visits). The next visit was on 5/29/14, 84 days later. The facility was asked to provide any additional evidence of physician visits, but none was provided. 2. Review of the medical record showed the last	F 387		

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F 387	Continued From page 14 documented physician visit for resident #38 was on 5/13/14. When asked to provide additional documentation, the facility submitted a note dated 6/5/14 which indicated the power of attorney (POA) declined to have the resident evaluated for an acute condition (swelling of hand). However, there lacked evidence the POA had refused any routine physician visit. 3. Review of physician progress notes for resident #8 showed the resident was seen by a physician on 1/14/14 and then again on 5/13/14 (119 days later). There lacked evidence of a physician visit since 5/13/14. When asked to provide evidence of other physician visits, the facility provided a "record of physician visit" dated 4/4/14 which indicated it was for the "cardio clinic." The only note from the physician was "no changes" and to follow-up in 6 months. There lacked evidence the physician evaluated the total program of care, including all medications and treatments. 4. Review of physician progress notes for resident #29 showed the resident was last seen by a physician on 9/23/13 (314 days ago). The facility was asked to provide any additional evidence of physician visits, but none was provided. 5. Review of physician progress notes for resident #27 showed the resident was seen by a physician on 1/14/14 and then 5/13/14 (119 days between visits). Additionally, it had been 82 days since the last visit on 5/13/14. The facility was asked to provide any additional evidence of physician visits, but none was provided. 6. During an interview on 8/7/14 at 11:05 AM, the	F 387	The facility will ensure that all residents will be seen by a physician at least once every 30 days for the first 90 days after admission and a least once every 60 days thereafter. 1. Resident # 16, 38, 8, 29 and 27 will be seen every 60 days by a physician and the physician will address the resident's total program of care. 2. All residents will be seen every 60 days by a physician and the physician will address the resident's total program of care. 3. Facility NHA or designee will talk to the hospital and Medical director to ensure that all residents are seen at their appropriate times and that their total program of care is addressed. 4. The resident's appointment dates will be monitored by medical records or designee on monthly basis and brought to QAPI until resolved. This will be tracked via a spread sheet. Res. #16 seen 8/12/14 #38 seen 8/12/14 #8 seen 8/12/14 #29 ~~seen~~ expired 8/17/14. #27 seen 8/12/14. 2. All facility residents were reviewed for timely physician visits, and any needing to be seen by their physician were seen.	9/4/14 9/20/14

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

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F 387	Continued From page 15 DON and LPN #1 stated the facility was aware there were problems with physician visits and they were working to address the issue.	F 387		

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