Plan of correction reviewed with correction made on pg 1 of 16. POC reviewed and approved by Derek Schmidt Exec Dir

DEPARTMENT OF HEALTH AND HUM... SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2005
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
	535032	A. BUILDING 1033 B. WING	03/03/2005

3/28/05 via phone Anita Meeks RN

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CHEYENNE	1330 PRAIRIE AVENUE CHEYENNE, WY 82009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based upon medical record review and staff interview, the facility failed to assure that seven (#34, #55, #60, #65, #70, #89, #118) of 24 sample records contained complete assessments or that all assessment items were accurate. The findings were: 1. Review of the 12/8/04 significant change Minimum Data Set (MDS) assessment revealed	F 278	F278 Resident Assessment The assessment will accurately reflect the resident's status. A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals. A) The significant change Minimum Data Set (MDS) dated 12/8/04 for resident # 55 will be corrected to reflect the correct information regarding the daily administration of an antidepressant. B) Regarding the completion of sections VB3 and VB4: this problem had been identified prior to the survey. Effective March 1, 2005 the care plan team is to ensure that VB4 is dated during the care plan conference. VB3 will be signed by the person facilitating the care plan decision making. C) A random weekly audit will be conducted of various Minimum Data Sets to ensure compliance with correct coding of psychotropic medications and also VB3 and 4 to ensure signature and date are present. D) A Performance Improvement Monitoring Tool will be utilized to perform random weekly audits. If a problem is noted then immediate education will take place. These weekly audits will be performed by the Assistant Director of Nursing. E) The Director of Nursing will report results of these audits at the	4/18/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE E.D. (X6) DATE 3/21/05

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MAR 24 2005
WYOMING DEPT OF HEALTH
HEALTH FACILITIES

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.

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F 278	Continued From page 1 resident #55 did not receive antidepressant medications. However, review of physician orders showed an 11/24/03 order for Lexapro (antidepressant) 10 milligrams (mg) everyday. Review of the medication administration record for November 2004 and December 2004 revealed the resident received Lexapro 10 mg everyday. During an interview on 3/2/05 at 1:40 PM, the two MDS coordinators stated the assessment was coded incorrectly; the resident did receive an antidepressant medication. 2. Review of the individual Minimum Data Set (MDS) assessments showed staff failed to complete Sections VB3 and VB4 on the MDS assessments for the following residents: a. Resident #34 for the 2/11/05 significant change assessment; b. Resident #55 for the 12/8/04 significant change assessment; c. Resident #60 for the 8/27/04 annual assessment; d. Resident #65 for the 11/2/04 annual and 1/21/05 significant change MDS assessments; e. Resident #70 for the 9/3/04 significant change assessment; f. Resident #89 for the 1/20/05 significant change assessment; g. Resident #118 for the 2/4/05 significant change assessment. During an interview on 3/2/05 at 1:40 PM, the two MDS coordinators and director of nursing (DON) stated a staff member should be signing and dating section VB 3 and 4 during the care planning conferences, but confirmed that some assessments lacked the signatures. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised	F 278	monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	4/18/05

POC reviewed and approved
3/28/05
1055 O'Neill RN

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F 278	Continued From page 2 Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section VB3 is for the signature of the person facilitating the care planning decision-making; Section VB4 is the date on which a staff member completes the care planning decision column after the care plan is completed. Both sections must be completed.	F 278		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable 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 following: 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 s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a care plan which addressed appropriate interventions related to renal (kidney) dialysis for one (#60) of two residents who received dialysis. The findings were:	F 279	F279 Resident Assessment The facility will develop a comprehensive care plan for each resident that includes measurable 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 will describe the following: 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 s483.25. A) An appropriate problem with goal and interventions was developed for resident #60 and is now part of the care plan. B) The same was completed for the other resident that receives dialysis. C) Random monitoring will be completed to ensure that the care plans are being followed in regards to the dialysis problem. D) A Performance Improvement Monitoring Tool will be utilized for	4/18/05

POC reviewed and approved
3/28/05
1055 a.m. RN

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F 279	Continued From page 3 Review of the 1/3/05 history and physical showed resident #60 was diagnosed with end-stage renal disease, had a brachiobasilic arteriovenous fistula (shunt from an artery to a vein), and received dialysis three times a week. Interview with a registered nurse (RN, employee #46) on 3/2/05 at 3:15 PM confirmed the resident received dialysis every Monday, Wednesday, and Friday. However, the care plan lacked interventions which addressed the psychosocial aspects of dialysis, infection control, or any necessary precautionary measures which should be taken before and after dialysis. Interviews with the unit manager on 3/2/05 at 2:45 PM and the director of nursing on 3/2/05 at 3:50 PM confirmed the lack of a care plan.	F 279	random monitoring. Any problems will be identified and immediate education will take place. The monitoring will be completed by the Staff Development Coordinator. E) The Director of Nursing will conduct an inservice for all nursing staff about developing comprehensive care plans. This will be completed on or before April 18, 2005. F) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to assure staff administered medications according to accepted professional standards of practice. During one of two medication passes, medications were in unlabeled containers and handled in a manner which caused contamination. The findings were: 1. Observation during a medication pass on 2/28/05 at 4:45 PM showed three unlabeled medication cups in the top drawer of one of the medication carts. Each cup was filled with a different medication. The registered nurse (RN,	F 281	F281 The services provided or arranged by the facility will meet professional standards of quality. A) All Licensed Nursing Staff will be re-educated regarding administering medications only from containers with labels that are clearly marked and legible and also about using clean technique when passing medications. This inservice will be conducted by the Director of Nursing and will take place on or before April 18, 2005. B) Random monitoring of med passes will be conducted weekly. These will include resident #24.	4/18/05

POC reviewed and approved 3/28/05 1055 amelk RN

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F 281	Continued From page 4 employee #47) who was using the cart at that time identified the medications as Colace, Multivitamins, and Calcium with Vitamin D. When questioned further, the RN denied removing the medications from the original bottles and placing them into the cups. Interview with the director of nursing (DON) on 3/3/05 at 8:40 AM revealed medications should not be placed in unlabeled containers; it's a "professional standard." According to the 3rd edition, 2004, of "Nursing Interventions & Clinical Skills", by Elkin, Perry, and Potter, "The nurse compares the label of the drug with the MAR [medication administration record] at least 3 times...This is the first check for accuracy....Give medications only from containers with labels that are clearly marked and legible." 2. On 2/28/05 at 5:00 PM observation showed a licensed practical nurse (LPN, employee #12) prepared medications which included Ditropan XL 10 milligrams and Calcium with Vitamin D for resident #24. While reaching for another medication, the LPN knocked the aforementioned medications out of the medication cup and onto the cover of the MAR, which was grimy, discolored, and sprinkled with flecks of a white substance. The LPN picked the contaminated medications up from the MAR cover, put them back into the medication cup, and administered them to the resident. Interview with the DON on 3/2/05 at 2:15 PM revealed it was not acceptable to administer contaminated medications to residents. The DON stated she did not have a policy and procedure related to medical asepsis (clean technique to prevent the spread of bacteria) while administering medications, but it was "an infection control issue" to pick the medications up off the MAR cover and give them to the resident.	F 281	C) A Performance Improvement Monitoring Tool will be utilized to conduct the random monitoring. The monitoring will be conducted by the Nurse Managers, the Assistant Director of Nursing, and the Staff Development Coordinator. If any problem is noted immediate education will take place. D) The Director of Nursing will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	4/18/05

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F 281	Continued From page 5 According to "Nursing Interventions & Clinical Skills", 3rd edition, 2004, by Elkin, Perry, and Potter, and "Clinical Nursing Skills," 6th edition, 2004, by Smith, Duell, and Martin, nosocomial (acquired in a healthcare facility) infections present a significant hazard in all health care settings. Further review showed interventions important to prevention of nosocomial infections include medical asepsis to "reduce the number of and prevent the spread of" bacteria.	F 281		
F 364 SS=D	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that ~~conserve~~ nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of facility policy, the facility failed to assure food items served during breakfast in the frontier dining room (one of four dining rooms) were palatable and at the proper temperature. The findings were: The following concerns were noted with the palatability and temperature of the foods in the Frontier dining room: a. Confidential interview with eight residents on 3/1/05 revealed food items including eggs, hot cereal, soup, and coffee and hot chocolate were frequently "cold" when served in the Frontier dining room. b. Observation in the kitchen on 3/2/05 revealed the frontier dining room meal trays,	F 364	F364 Each resident receives and the facility provides food prepared by methods that conserve nutritive value and appearance: and food that is palatable, attractive and at the proper temperature. A) Trays for the Frontier Dining room are now placed on plate warmers and covered. Hot cereal is served from the tray line versus preserving and holding in the warmer. Hot chocolate and coffee are now made and served in the Frontier Dining Room.	4/18/05

POC reviewed and approved 3/28/05 amell RN

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F 364	Continued From page 6 including a test tray requested by the surveyors, left the kitchen at 8:22 AM. At 8:25 AM, the surveyors poured a cup of hot chocolate from a pitcher located on a utility cart containing beverages for the residents in the frontier dining room. At 8:30 AM when the last resident was served, the test tray and the cup of hot chocolate were tested for taste and temperature with the following results: oatmeal- tepid at 120 degrees Fahrenheit (F), scrambled eggs- cool at 110 degrees F, and hot chocolate- luke-warm at 113 degrees F. c. Interview with the staff dietitian on 3/2/05 at 2:05 PM revealed hot plates should have been used during the breakfast meal service on 3/1/05; however, the plates had not been utilized. Further interview with the staff dietitian on 3/2/05 at 4:15 PM revealed that according to the corporate dietitian, an acceptable palatable temperature for hot food when served to the residents is 120 degrees F or higher, or whatever is acceptable to the residents. The staff dietitian also commented that an acceptable palatable temperature for hot foods would typically be higher than 120 degrees F. d. Interview with the staff dietitian on 3/2/05 at 4:05 PM revealed the temperature of the hot chocolate tested on 3/1/05 with a result of 113 degrees F, should have been the same temperature as the facility's policy for coffee. Review of the facility policy for serving temperatures revealed coffee should be served at 140 degrees F or higher, but preferably 165-175 degrees F.	F 364	B) The Dietician/Dietary Director will randomly take temperatures of trays in the Frontier Dining Room, if food temperatures are found not palatable a new tray will be provided and immediate steps will be taken to remedy the particular issue. The Dietician has and will randomly interview residents to ensure palatable foods are being served. C) Dietary staff was inserviced on palatable temperatures during survey. The Dietician will also provide immediate inservicing to cooks and aids when temperatures are low. D) The Dietician will report quarterly at the QI meeting the findings of her audits and observations. This will happen for one quarter or until compliance is achieved.	4/18/05
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

POC reviewed and approved 3/2 plus email AN

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policy, the facility failed to assure dietary staff properly handled frozen, raw meat and followed acceptable hand washing and gloving procedures. In addition, food service equipment was not maintained in a clean and sanitary manner. The findings were: 1. The following problems were noted with the thawing of frozen, raw meat: a. Observation in the kitchen on 3/1/05 at 9:53 AM revealed the preparation sink was one-half to two-thirds full of raw frozen chicken pieces floating in standing water. Interview with the preparation cook at 10:15 AM revealed the chicken pieces were removed from the freezer at 9:50 AM to be thawed and cleaned. Observation from 10:15 AM - 10:40 AM revealed the preparation cook removed the skin from the chicken pieces and placed the chicken on metal trays. At 10:40 AM the preparation cook emptied the standing water from the sink. The bottom of the sink was covered with chicken pieces. At 10:45 AM the preparation cook refilled the sink and covered the chicken pieces with cold standing water. Next, the preparation cook continued to remove the skin and place the chicken pieces on metal trays. At 11:03 AM the last piece of chicken was placed on a metal tray and the standing water ws drained from the sink. b. Observation in the food preparation area on 3/1/05 at 9:53 AM revealed four 10-pound rolls of raw hamburger were on the second shelf of a utility cart. Interview with the preparation cook at 10:15 AM revealed the hamburger was taken out of the refrigerator at 9:50 AM. At 11:05 AM, the	F 371	F371 The facility must store, distribute and served food under sanitary conditions. A) Dietary staff will now thaw meats at 41 F or completely submerged under continuously running water. During preparation, unpackaged foods shall be protected from environmental sources of contamination. Staff will follow hand washing policy and procedures. Gloves will only be used for one task and discarded. Dietary staff will wash and sanitize all surfaces, equipment and utensils that have come into contact with raw meats before using for any other food to prevent cross-contamination. The microwave on unit 3 will be cleaned every 24 hours per facility policy. B) The Dietician/Dietary Director will randomly observe sanitation procedures to ensure food is thawed, stored, distributed, packaged, and served under sanitary conditions. The Dietician/Dietary Director will also randomly observe the use of single use gloves. The Dietician/Dietary Director will randomly audit the microwave on unit 3 to ensure cleaning. If policy & procedures are not	4/18/05

POC reviewed and approved 3/28/05 amell a

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F 371	Continued From page 8 preparation cook removed the hamburger from the cart to make meatloaf. At that time at the request of the surveyors, the preparation cook took the temperature of the hamburger with a result of 41 degrees Fahrenheit (F). At 11:30 AM the preparation cook transported the meatloaf to the walk-in refrigerator. Interview with the preparation cook on that same date at 1:35 PM, revealed the hamburger was placed on the utility cart to allow the meat to continue to thaw so he could "work" the hamburger into meatloaf. c. Review of the facility policy Section 3: Receiving, Inventory and Storage, entitled Food Storage, showed: "Thawing: Thaw foods at 41 degrees Fahrenheit or less or in an airtight bag under cold running water." Interview with the staff dietitian and the dietary supervisor on 3/3/05 at 8:35 AM confirmed the kitchen staff were expected to follow this policy. According to Food Code 2001, U.S. Public Health Service Thawing 3-501.13: ...Potentially hazardous foods shall be thawed: (A) under refrigeration that maintained the food temperature at 41 degrees F or less...; B) Completely submerged under running water... 2. The following problems were noted with partially unwrapped, uncovered frozen meat in the food preparation area: Observation in the food preparation area of the kitchen on 3/1/05 at 9:53 AM revealed two boxes of turkey roasts on the bottom shelf of a utility cart. At 11:31 AM the preparation cook removed the frozen turkeys from the boxes and tore off between one-third and one-half of the plastic wrapping from each turkey roast. The partially unwrapped, uncovered roasts remained on top of a utility cart in the food preparation area while the preparation cook assisted on the tray	F 371	followed immediate inservicing will take place. C) The Dietician/Dietary Director have inserviced kitchen staff on thawing, cleaning, storing, packaging, and sanitation procedures. D) The Dietician will report quarterly at the QI meeting on her audits and observations. This will occur for one quarter or until compliance is achieved.	4/18/05

POC reviewed and approved 3/28/05 ameth RN

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F 371	Continued From page 9 line for the noon meal. At 1:10 PM (1 hour and 39 minutes after the plastic wrapping was partially removed) the remaining plastic wrap was taken off and the uncovered turkey roasts were place in metal pans and transported to the walk-in refrigerator. According to Food Code 2001, U.S. Public Health Service Food Preparation 3-305.14: During preparation, unpackaged food shall be protected from environmental sources of contamination. 3. The following problems were noted with proper hand washing and the use of gloves: Observation on 3/1/05 at 11:25 AM revealed the preparation cook rinsed his gloved hands under running water at the preparation sink after handling raw hamburger. Then, while wearing the same gloves, he continued to perform other tasks such as covering pans of meatloaf with cellophane wrap and handling boxes of frozen doughnuts. Review of the facility policy Section 2: Personnel Management, entitled Handwashing and Glove Use, revealed that when gloves are used, gloves may be used for one task only. Interview with the staff dietitian and the dietary supervisor on 3/3/05 at 8:35 AM confirmed dietary staff were expected to follow this policy. According to Food Code 2001, U.S. Public Health Service, Gloves Use and Limitation 3-304.15: (A) If used, single-use gloves shall be used for only one task...used for no other purpose and discarded when damaged, soiled, or when interruptions occur in the operation. 4. The following problems were noted with the proper sanitization and cleanliness of the food service equipment:	F 371		4/28/05

POC reviewed and approved 3/28/05 Amelia RN

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F 371	Continued From page 10 a. Observation in the kitchen on 3/1/05 at 11:25 AM revealed the preparation cook wiped down a utility cart with a wet towel that was lying on the counter. The utility cart had blood on the second shelf from raw hamburger. The preparation cook did not spray sanitizer onto the towel or the cart in the process. Two pans of meatloaf were then placed onto the utility cart and put in the walk-in refrigerator. Interview with the preparation cook on the same date at 1:35 PM revealed the procedure for sanitizing equipment was to spray the pre-mixed sanitizer from a spray bottle onto surfaces that need cleaning and then wipe them down. Review of the facility policy Section 3: Receiving, Inventory and Storage, entitled Food Storage, showed that when handling raw meat: "Wash and sanitize all surfaces, equipment, and utensils that have come in contact with raw meats before using for any other food to prevent cross-contamination." According to the Food Code 2001, U.S. Public Health Service Sanitization of Equipment and Utensils 4-703.11: After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: (C) Chemical manual or mechanical operations including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods... b. Observation on 3/1/05 at 4:00 PM, 3/2/05 at 9:40 AM, then again on 3/3/05 at 8:30 AM, revealed the interior walls and ceiling of the pantry microwave oven were splattered with an excessive accumulation of dried-on food material. The microwave oven was located in the pantry next to the nurses' station #3 and across the hall from the special care unit dining room. Interview with the director of housekeeping on 3/2/05 at	F 371		4/18/05

POC
reviewed
and approved
3/28/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535032	A. BUILDING _____ B. WING _____	03/03/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 11 4:30 PM revealed both the staff and the residents used the microwave oven. c. Interview with the dietary supervisor on 3/3/05 at 8:40 AM revealed dietary staff were scheduled to clean the microwave oven every other week. Review of the facility policy Section 8: Equipment, Operation, Infection Control, and Sanitation, entitled Microwave Oven, revealed the inside of the oven was to be cleaned daily paying particular attention to the inside of the door. According to Food Code 2001, U.S. Public Health Service Cleaning of Equipment and Utensils 4-602.12: Cooking and Baking Equipment (B) The cavities and door seals of microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure.	F 371		
F 387 SS=D	483.40(c)(1)&(2) PHYSICIAN SERVICES 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, staff interviews, and review of signed physician agreements, the facility failed to assure physician visits occurred at least every 60 days for 2 (#75, #89) of 24 sample residents. The findings were: 1. Review of the physician's progress notes	F 387	F387 Physician Services The resident will 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) The HIM Director will continue to send reminder letters to physicians to remind them to see their patients in a timely manner. B) The HIM Director will provide a copy of this letter to the Director of Nursing, the Executive Director and the Medical Director. The Director of Nursing will follow the letter with a phone call to remind the physician to see his/her patient.	4/18/05

POC reviewed and approved 3/28/05 ameller

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F 387	Continued From page 12 showed the physician did not see resident #89 from 8/30/04 until 2/9/05, a period of over five months. Review of the entire medical record and interview with the unit manager (employee #21) confirmed the lack of physician visits during that time period. Further review of the medical record revealed a signed agreement that the physician would comply with federal regulations and see the resident every 60 days. The agreement was signed by the physician on 4/27/04. Interview with the director of health information management (HIM) on 3/2/05 at 1:03 PM revealed it was sometimes difficult to get physicians to see the residents. The HIM director stated the facility sent letters to the physicians reminding them of the need to see the residents, but the physicians still missed the visits. Review of those letters showed the physician was notified on 12/10/04 and 1/27/05 that the last visit to resident #89 was on 8/30/04; however, the physician did not examine the resident until 2/9/05. 2. Review of the physician's progress notes showed the physician did not see resident #75 from 9/22/04 until 12/22/04, a period of 90 days. Interview with the unit manager (employee #10) on 3/2/05 at 2:30 PM confirmed the lack of physician visits during that time period. Review of the medical record showed an agreement signed by the physician that s/he would see the resident every 60 days. The physician signed the agreement on 9/29/04.	F 387	C) If the physician still does not see the patient, then arrangements will be made with the Medical Director to see the patient and the Medical Director will speak with the physician. D) The HIM Director will continue to audit for physician visits monthly and will maintain the audit log. E) The HIM Director will report results of these audits at the monthly Performance Improvement Meeting. The report will include any problems and/or trends noted. This will occur for a period of no less than three months or until ongoing compliance has been achieved.	4/18/05
F 465 SS=D	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

POC
reviewed and
approved 3/28/05
amiller RN

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F 465	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations on three of three days of survey, and staff interview the facility failed to assure the floor in the walk-in freezer was maintained in a safe manner. The findings were: Observation on 2/28/05 at 1:25 PM revealed an excessive accumulation of ice build-up on the floor and ceiling in the walk-in freezer. The ice on the floor was located below the condenser which was attached to the ceiling and back wall of the freezer. The ice on the ceiling covered an area of at least one-foot in each side of the condenser. On 3/1/05 at 7:33 AM a cone-shaped accumulation of ice on the floor was measured at four inches in height and at least 1.5 inches in diameter. In addition, two patches of ice on the floor measured at least one foot in diameter. The ice on the floor was located in the walk way that kitchen staff needed to step on in order to have access to items in the back of the freezer. A third observation in the freezer on 3/2/05 at 7:36 AM revealed the ice was still present. During each of the three observations no physical precautions were present to alert dietary staff of the safety hazard. Interview with the dietary supervisor on 3/2/05 at 2:45 PM revealed the ice build-up occurred when the fans of the condenser were shut down for cleaning, and maintenance was notified of the ice build-up the first week in January, 2005. The dietary supervisor further commented the current ice accumulation had been there for a week to a week and a half, and although maintenance and outside contractors were working to find the source of the ice, it continued to be a problem.	F 465	F465 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A) Maintenance has defrosted the walk-in freezer and removed the ice. They also replaced all lines to the condenser, re-caulked all seams and ordered a new plastic curtain for the entry door to keep moisture out. B) The maintenance/dietary staff will randomly observe the walk-in freezer and it they find ice they will immediately remove. C) The maintenance staff will report quarterly at the QI meeting the findings of their observations. This will happen for one quarter or until compliance is achieved.	4/18/05

POC
reviewed and approved
4/28/05
amelia RN

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F 500	Continued From page 14	F 500	F500 Administration	4/18/05
F 500 SS=B	483.75(h)(1)&(2) ADMINISTRATION If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a written arrangement or agreement which specified the professional standards and principles of service, and the timeliness of the service, provided by the dialysis center for two (#60, #121) of two residents receiving renal (kidney) dialysis. The findings were: Review of each entire medical record for residents #60 and #121 failed to a reveal a contract or agreement with the dialysis center related to renal dialysis. During interviews with the administrator and director of nursing (DON) on 3/3/05 at 7:55 AM, each stated they were unaware of any formal agreement. After reviewing their filed contracts, both the administrator and	F 500	Arrangements as described in section 1861 (w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. A) The facility will obtain a contract or agreement with the dialysis center related to renal dialysis provided to any of our residents that require those services. B) Exec Dir will review contracts yrly and through QI process.	

POC
above correction reviewed and approved
Derek Schmidt exec D.r
3/28/05
1055 / amelia

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F 500	Continued From page 15 DON confirmed, on 3/3/05 at 8:45 AM, the facility did not have a written agreement with the dialysis center. Furthermore, the administrator stated the facility had never had a contract or agreement with the center.	F 500		4/18/05

POC reviewed and approved 2 exec Dir 3/28/05 / amiller RN