Approved & Changes on pages 2 and 11 after discussion & Chery Benavidez via phone on 8/15/2006 2:15 pm

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

PRINTED: 07/19/2006
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
	535045	A. BUILDING _____ B. WING _____ JUL 27 2006	07/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVNEUE H POWELL, WY 82435

Lenita Bleuss RN

(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 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure the activity program for one (#21) of 17 sample residents was implemented as planned. The findings were: According to the 6/13/06 activity assessment and 5/15/06 care plan, resident #21 enjoyed watching cartoons, "Animal Planet," and "Doug" on television. The care plan also documented the resident liked country music. However, observation from 7/10/06 at 4:20 PM through 6:55 PM, 7/11/06 from 7:25 AM through 6:30 PM, and 7/12/06 from 7:30 AM through 5:45 PM revealed neither the resident's television nor the radio was on while the resident was in the room. During those time periods, the resident was left to look continuously at the same mobiles, the ceiling, or the padded side rails. Interview with the director of resident care services and the Minimum Data Set coordinator on 7/13/06 at 8:20 AM revealed anyone could turn the television or radio on for the resident; the tasks were not specifically assigned to a department.	F 248	F 248 The facility will ensure that there is an ongoing program of activities. This will be accomplished by, A. An Activity Aides has been assigned to ensure that the television or radio is on in resident #21's room. B. All residents have the potential to be affected by the lack of an ongoing activities program designed to meet the physical, mental and psychosocial well-being of each resident. C. Each activity aide has been assigned a segment of the resident population to ensure that the resident's desired leisure pursuits are met. D. The Activities Director will perform a random audit comparing the residents' desired activities against the resident's attendance at activities. The data will be aggregated quarterly and submitted to the Medical Director and the Quality Council.	8/21/2006

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 7-26-06

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 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 and staff interview, the facility failed to complete comprehensive assessments for all needed areas for three of 20 sample residents (#3, #40, #91).	F 272	F 272 The facility will ensure that comprehensive assessments of each resident are performed initially and periodically. This will be accomplished by, A. 1. The Activity Director will complete a comprehensive assessment of resident ~~#3~~ #91. A. 2. A comprehensive pain assessment will be completed on resident #3 by the Nursing Director. A. 3. A comprehensive pain assessment will be completed on resident #40 by the Nursing Director. The resident's primary physician will review the resident's complaints of insomnia and determine appropriate treatment. B. All residents have the potential to be affected by the lack of comprehensive assessments. C. 1. All residents will have an initial comprehensive assessment to include past, current and future activity pursuits and desires. Chgd via phone request by Chris Benander 9/3/06 @ 2:15pm	

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F 272	Continued From page 2 The findings were: 1. Review of the 5/23/06 admission Minimum Data Set (MDS) assessment revealed resident #91 spent some (1/3 to 2/3 of time) time in activities. Review of the 5/10/06 initial activity assessment revealed it was incomplete. The area for activity pursuit patterns was blank. There was a note on the assessment which read "Resident unable to answer any questions. Will visit with family at a later date." Review of the medical record revealed that as of 7/12/06, there was not a completed activity assessment. During an interview on 7/12/06 at 3:25 PM, the activity director confirmed the assessment was not complete, and stated the resident needed to be re-assessed. 2 Review of the 10/31/05 significant change Minimum Data Set (MDS) assessment showed resident #3 experienced mild pain less than every day. According to the 5/1/06 quarterly MDS assessment, the pain had increased to moderate intensity, but occurred less than daily. However, review of the entire medical record failed to reveal a current pain assessment. Interview with the director of nursing services (DNS) #1 on 7/13/06 at 10:40 AM confirmed lack of a pain assessment. 3. According to the 9/12/05 annual MDS assessment, resident #40 had daily pain of moderate intensity and received an hypnotic (sleeping pill). Review of the 6/12/06 quarterly MDS assessment showed the resident continued to experience daily mild pain and receive the hypnotic. Review of the medication administration	F 272	F 272-cont. C. 2. All residents will have an initial comprehensive assessment to include pain and sleep patterns. Follow-up pain assessments will be completed quarterly and as needed. The frequency of hypnotic use will be assessed quarterly and reported to the physician for evaluation of continued use. D. The completion rate activity assessments, pain assessments and hypnotic usage will be aggregated quarterly and reported to the Medical Director and Quality Council.	8/21/2006

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F 272	Continued From page 3 record (MAR) and interview with the MDS coordinator on 7/12/06 at 3:30 PM confirmed the resident received the hypnotic nightly. However, there was no current pain assessment or assessment for insomnia in the medical record. On 7/13/06 at 10:50 AM, interview with DNS #2 confirmed both assessments were lacking.	F 272		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for one (#3) of three sample residents requiring that assessment. The findings were: Review of the 5/1/06 quarterly MDS assessment	F 274	F 274 The facility will ensure that a comprehensive assessment will be completed within 14 days after determining there has been a significant change of condition. This will be accomplished by, A. A significant change of condition will be completed on resident #3. B. All who experience a significant change of condition have the potential to be affected by the lack of interdisciplinary review or revision. C. The primary nurse will notify the MDS/Restorative Director of any resident changes of condition.	

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F 274	Continued From page 4 showed resident #3 declined from requiring limited staff assistance in the areas of transferring, bed mobility, ambulation, and dressing to needing extensive assistance to complete the tasks. In addition, the resident developed limited range of motion in one leg with partial loss of voluntary movement. Furthermore, the resident's bladder status declined and urinary incontinence occurred daily. However, the facility failed to complete a significant change assessment to determine the causative and contributing factors for the declines in the aforementioned areas. During an interview on 7/12/06 at 4 PM, the MDS coordinator stated a significant change assessment should have been completed.	F 274	F274-cont. D. The MDS/Restorative Director will compare the quarterly MDS assessments with previous quarterly assessments to determine if changes were identified that were missed. This information will be aggregated quarterly and submitted to the Medical Director and the Quality Council.	8/21/2006
F 282 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to follow the written plans of care for four of 17 sample residents (#14, #21, #89, #91). The findings were: 1. Review of the 12/19/05 admission and 6/19/06 quarterly Minimum Data Set (MDS) assessments revealed resident #14 was dependent on staff for eating. Review of the 6/19/06 care plan revealed	F 282	F 282 The facility will ensure that services are provided by qualified persons in accordance with each resident's written plan of care. This will be accomplished by, A. 1. All nursing staff will be instructed to follow the plan of care for resident #14 which states, "...make sure resident is upright in chair before feeding", as well as repositioning the resident as needed.	

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F 282	Continued From page 5 staff should "...make sure resident is upright in chair before feeding." The following concerns were identified regarding the failure to follow the care plan: a. Observation on 7/10/06 from 6:05 PM until 6:42 PM revealed registered nurse (RN) #2 fed the resident. The resident was not upright in the geri-chair (wheeled reclining chair), but rather was reclined at approximately 150 degrees. The resident's head was back, with his/her face towards the ceiling. As the RN gave the resident fluids, some of the liquid spilled out of the resident's mouth, down the resident's cheeks. No attempts to re-position the resident were made. b. Observation on 7/11/06 at 8:25 AM and 8:40 AM revealed the resident was reclined at approximately 100 degrees, and was scooted down in the geri-chair. The resident's head was not in a neutral position. Certified nurse aide (CNA) #1 fed the resident in the reclined position, and made no attempts to re-position the resident. c. Observation on 7/11/06 at 6:06 PM and 6:20 PM revealed the resident was fed by a family member. The resident was reclined to approximately 145 to 150 degrees, and had a pillow under the head. The resident's head was back, with his/her face towards the ceiling. No staff intervened to re-position the resident. During an interview on 7/12/06 at 3:40 PM, the director of resident care services stated the resident was to be positioned in an upright position. 2. Review of the 2/28/06 dehydration RAP (resident assessment protocol) module showed resident #89 was at high risk for dehydration related to dementia and contractures of the hands. The module documented the resident	F 282	F 282-cont. A. 2. All nursing staff will be instructed to offer and encourage resident #89 to drink fluids. A visual tool will be placed in resident #89's room to remind staff to offer fluids. A. 3. Nursing staff will be instructed to give resident #91 thickened liquids with medications and between meals. A. 4. RN #3 will be instructed to follow the written care plan by checking the residual for resident #21 before giving medications or fluids. B. All residents have the potential to be affected by not following the residents' individualized care plan.	

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F 282	Continued From page 6 required assistance to drink fluids. The recommendations included "Encourage resident to drink in between meals, offer often and assist x 1 when needed..." The 5/30/06 care plan showed staff were to encourage the resident to drink between meals and offer fluids often. a. Observation of the resident on 7/11/06 revealed the resident was not offered fluids prior to breakfast (from 7:25 AM until 8:32 AM). The resident did not drink fluids for the breakfast meal. Observation from breakfast until lunch (8:32 AM until 12:15 PM) revealed staff did not offer or encourage fluids. During that time, at 10:35 AM, certified nurse aides (CNAs) # 2 and #3 took the resident to the bathroom and assisted the resident into the wheelchair, but did not offer fluids. According to the meal intake record, the resident refused fluids at the lunch meal. Observation of the resident at the evening meal (on 7/11/06) revealed the resident did not drink any fluids. After the evening meal, CNA #4 took the resident to the bathroom, provided oral care, and put the resident to bed for the night. The CNA did not offer fluids to the resident. b. During an interview on 7/12/06 at 4:15 PM, the MDS/restorative director stated staff should offer fluids between meals and each time they provide care to the residents. 3. Review of the 5/23/06 dehydration RAP module for resident #91 revealed CNA charting showed the resident's output exceeded intake. The module documented the resident was not able to drink fluids independently and was at high risk for dehydration. The recommendations included "offer and assist c [with] thickened fluids several x [times] ea [each] shift..."The 5/30/06 care plan instructed staff to offer and assist with thickened	F 282	F 282-cont. C. Instruction related to specific resident needs will be placed on the CNA and Nursing treatment documentation sheets. Visual tools will be placed in each resident's room for those identified at risk for dehydration. D. A random visual and documentation audit will be performed on residents and treatment documentation sheets by the MDS/Restorative Director. The Director of Nutritional Services will provide data regarding pre-thickened liquid usage to the MDS/Restorative Director quarterly. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council.	8/21/2006

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F 282	Continued From page 7 liquids several times per shift. a. Observation on 7/11/06 at 8 AM revealed CNAs #5 and #6 assisted the resident out of bed, took the resident to the bathroom, and put the resident in a wheelchair. The resident was not offered fluids. During the breakfast meal (8:25 AM-9 AM), the resident only received one glass of juice (180 cubic centimeters). The resident drank the juice, but was not offered any more fluids. From 9 AM until 12:15 PM, the resident was not offered fluids. During that time, at 9:50 AM and 11:52 AM, CNAs #5 and #6 provided cares to the resident, but did not offer fluids. Review of the intake record showed the resident only consumed 120 cc at the lunch meal. b. During an interview on 7/12/06 at 4:15 PM, the MDS/restorative director stated staff should offer fluids between meals and each time they provide care to the residents. 4. Observation on 7/11/06 at 7:25 AM revealed resident #21 had a gastrostomy (feeding) tube. According to the 5/15/06 care plan, staff were to "check residual before feeding"; if the residual amount was above 100 milliliters (ml), they were to hold the feeding for one hour, recheck for residual, and administer the feeding only if the amount was below 100 ml. Observation at 11:45 AM showed registered nurse (RN) #3 prepared and administered medications and a can of Isosource VHN (tube feeding) without checking for residual stomach contents. During an interview immediately after the observation, the RN stated she "probably should have checked for residual." Interview with the director of resident care services on 7/12/06 at 11:45 AM and review of documentation (last revised 3/06) related to the	F 282		

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F 282	Continued From page 8 facility's procedure manual revealed the facility used the "Advanced and Basic Nursing Procedures set down in the Lippincott Williams & Wilkins 'Nursing Procedures, Edition IV.'" Review of the procedure for tube feeding showed "To assess gastric emptying, aspirate and measure residual gastric contents." Review of the 5/15/06 care plan showed the resident enjoyed cartoons, Animal Planet, and "Doug" on television. In addition, the care plan documented the resident also liked country music. However, observation from 7/10/06 at 4:20 PM through 6:55 PM, 7/11/06 from 7:25 AM through 6:30 PM, and 7/12/06 from 7:30 AM through 5:45 PM revealed the care plan was not implemented as neither the resident's television nor radio was on. Interview with the director of resident care services and Minimum Data Set coordinator on 7/13/06 at 8:20 AM revealed anyone could turn the television or radio on; the tasks were not specifically assigned to a specific department.	F 282		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 309	F 309 The facility will ensure that the necessary care and services for each resident to attain or maintain the highest practicable physical, mental and psychosocial well-being is provided. This will be accomplished by,	

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F 309	Continued From page 9 and staff interview, the facility failed to position one of two residents (#14) in a geri-chair (wheeled reclining chair) in a manner that facilitated the resident's ability to eat and swallow. The findings were: Review of the 12/19/05 admission and 6/19/06 quarterly Minimum Data Set (MDS) assessments revealed resident #14 was dependent on staff for eating. Review of the 6/15/06 nutrition assessment showed the resident was fed by staff in the assisted dining room. Review of the 6/19/06 care plan revealed staff should "...make sure resident is upright in chair before feeding." Observation on 7/11/06 at 8:25 AM in the assisted dining room revealed instructions on dining were posted on the wall. The instructions included that the resident's head and neck should be in an upright position, with the chin slightly tucked. The following concerns were identified: a. Observation on 7/10/06 from 6:05 PM until 6:42 PM revealed registered nurse (RN) #2 fed the resident. The resident was not upright in the geri-chair, but rather was reclined at approximately 150 degrees. The resident's head was back, with his/her face towards the ceiling. As the RN gave the resident fluids, some of the liquid spilled out of the resident's mouth, down the resident's cheeks. No attempts to re-position the resident were made. b. Observation on 7/11/06 at 8:25 AM and 8:40 AM revealed the resident was reclined at approximately 100 degrees, and was scooted down in the geri-chair. The resident's head was not in a neutral position. Certified nurse aide (CNA) #1 fed the resident in the reclined position, and made no attempts to re-position the resident. c. Observation on 7/11/06 at 6:06 PM PM and	F 309	F 309-cont. A. All nursing staff will be instructed to follow the plan of care for resident #14 which states, "...make sure resident is upright in chair before feeding", as well as repositioning the resident as needed. B. All resident have the potential to be affected by the lack of necessary care to attain or maintain the highest practicable physical, mental and psychosocial well-being. C. Instruction related to specific resident needs will be placed on the CNA and Nurse Treatment Documentation sheets. D. A random documentation audit will be performed on treatment documentation sheets by the MDS/Restorative Director. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council.	8/21/2006

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F 309	Continued From page 10 6:20 PM revealed the resident was fed by a family member. The resident was reclined to approximately 145 to 150 degrees, and had a pillow under the head. The resident's head was back, with his/her face towards the ceiling. No staff intervened to re-position the resident. During an interview on 7/12/06 at 3:40 PM, the director of resident care services stated the resident should be positioned in an upright position.	F 309		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure three (#3, #5, #90) of four sample residents received the appropriate services to maintain or improve each individual's ability to ambulate. The findings were: 1. According to the restorative care plan, resident #3 was to ambulate four times a week. Review of restorative documentation from April through July 12, 2006 showed the resident was ambulated as planned for three of four weeks in April, two of four weeks in May, two of four weeks in June, and two of the first two weeks in July. 2. According to the restorative care plan, resident #5 was to ambulate four times a week. Review of restorative documentation from April through July	F 311	F 311 The facility will ensure that each resident is given the appropriate treatment and services to maintain or improve his or her abilities. This will be accomplished by, A. 1. Resident #3 will be re-evaluated by the physical therapist and recommendations will be followed. A. 2. Resident #5 will be re-evaluated by the physical therapist and recommendations will be followed. A. 3. The frequency of restorative therapy will be identified and documented on resident #90's flow sheet. and recommendations/frequency will be followed add'l per request of Cheri Bellamy via phone 8/3/06 2:15pm	

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	535045	A. BUILDING _____ B. WING _____	07/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVNEUE H POWELL, WY 82435

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F 311	Continued From page 11 12, 2006 showed the resident was ambulated three times during the week of April 15th through the 21st, three times from May 6th through the 12th, twice from May 13th through the 19th, twice from May 20th through the 26th, once from June 3rd through the 9th, and three times from June 10 through the 16th. 3. Review of the 5/8/06 quarterly Minimum Data Set (MDS) assessment revealed resident #90 required extensive assistance to ambulate in the corridor. Review of a 10/27/05 occupational therapy note revealed a restorative program was set up to include ambulation. The care plan dated 5/8/06 showed the resident was working with restorative on ambulation. During an interview on 7/13/06 at 9:45 AM, restorative nurse aide (RNA) #1 stated the resident was supposed to ambulate or ride the bike four times per week. The following concerns were identified: a. Review of the May 2006 restorative flow sheet showed the frequency was not identified. On 7/13/06 at 10:10 AM, the restorative director stated the resident was supposed to receive services four times per week in May. According to the May 2006 restorative record, the resident did not receive services four times per week during any of the weeks (none the week of 5/7, twice the week of 5/14, three times the week of 5/21, and once the week of 5/28). b. Review of the June 2006 restorative flow record showed the resident was supposed to receive services five times per week. However, the resident did not receive services five times per week during any of the weeks (twice the weeks of 6/4 and 6/11, three times the week of 6/18, and once the week of 6/25). During an interview on 7/12/06 at 3:40 PM, the	F 311	F 311- cont. A. 4. Restorative Aides will be in-serviced on the importance of following the recommendations of the physical therapist and the restorative plan of care. B. All residents have the potential to be affected by adhering inconsistently to the established restorative therapy plan of treatment. C. All frequencies will be clearly identified on each restorative flow sheet. The restorative aides will be in-serviced on the importance of following the prescribed restorative plan. D. The MDS/Restorative Director and the Restorative Nurse, will audit restorative flow sheets every two weeks. Data will be aggregated quarterly and reported to the Medical Director and Quality Council.	8/21/2006

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F 311	Continued From page 12 director of resident care services stated she assumed if it was not documented, it was not done. 4. Interview with restorative aide (RA) #1 on 7/13/06 at 10 AM revealed staff tried to complete the restorative program as planned, but sometimes they missed some residents. However, the RA did confirm the accuracy of the restorative documentation; she stated if the program was completed as planned, it was definitely documented.	F 311		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interviews, the facility failed to assure three (#14, #21, #26) of four sample residents received range of motion (ROM) exercises as planned. The findings were: 1. Review of the 12/19/05 admission and 6/19/06 quarterly Minimum Data Set (MDS) assessments revealed resident #14 had range of motion limitations to the neck, one arm, one hand, both legs and both feet. Review of the 6/14/06	F 318	F 318 Based on the comprehensive assessment the facility will ensure that residents with a limited range of motion will receive the appropriate treatment and services to increase or prevent further decrease in his or her range of motion. This will be accomplished by, A. 1. Restorative aides will be instructed to follow the prescribed treatment plan for resident #14. A. 2. Restorative aides will be instructed to follow the prescribed treatment plan for resident #21.	

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F 318	Continued From page 13 activities of daily living and restorative assessment and the 2/21/06 physical therapy note showed the resident had contractures present. The 2/21/06 physical therapy note and July 2006 restorative care flow record documented the resident was supposed to receive range of motion services four times per week by restorative aides. Review of the May, June, and July 2006 restorative flow records revealed the resident did not receive services 4 times per week on the following weeks: a. Week of May 7th- twice b. Week of May 14th- once c. Week of May 21st- twice d. Week of May 28th- once e. Week of June 4th- twice f. Week of June 11th- once g. Week of June 18th- twice h. Week of June 25th- twice i. Week of July 2nd- twice During an interview on 7/12/06 at 3:40 PM, the director of resident care services stated she assumed if it was not documented, it was not done. 2. Observation on 7/1/06 at 10:18 AM showed resident #21 had bilateral contractures of the hands and feet and required extensive assistance from staff with transfers. Review of the restorative program showed the resident was to receive bilateral upper and lower extremity ROM exercises four times a week to maintain the resident's current ROM level. However, review of the documentation for April through July 2006 showed ROM exercises were provided as follows: a. Four times from April 1st through the 7th, not at all during the week of April 8th through 14th, once from April 15th through the 21st, and	F 318	F 318-cont. A. 3. Restorative aides will be instructed to follow the prescribed treatment plan for resident #26. A. 4. Restorative aide #1 as well as other restorative aides will be instructed to document reasons for missed treatments. B. All residents with a limited range of motion have the potential to be affected by the lack of appropriate treatment and services to increase or prevent further decreases in range of motion. C. All frequencies will be clearly identified on each restorative flow sheet. The restorative aides will be in-serviced on the importance of following the prescribed restorative plan. D. The MDS/Restorative Director and the Restorative Nurse will audit restorative flow sheets every two weeks. Data will be aggregated quarterly and reported to the Medical Director and Quality Council.	8/21/2006

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F 318	Continued From page 14	F 318		

twice from April 22nd through the 28th. Notations on the documentation form showed no therapy was provided on April 9th, 13th, 21st, 23rd, and 30th, but no reason for the lack of therapy was given.

b. During the month of May, the exercises were provided on the 1st, 5th, 6th, 7th, 8th, 10th, 18th, 19th, 25th, and 31st. May 3rd was circled as not given, but no explanation was documented.

c. The exercises were provided on June 5th, 16th, 19th, 21st, 23rd, and 26th. The documentation indicated no therapy was provided on the 4th and 30th, but no explanation was given. In addition, a line was drawn through June 18th, but no explanation was provided.

d. ROM exercises were documented as completed on the 9th and 10th for July 2006.

3. Review of the 8/8/05 annual Minimum Data Set (MDS) assessment showed resident #26 was admitted with diagnoses which included multiple sclerosis. Further review revealed the resident had bilateral limitations with ROM in the neck, legs, and feet as well as partial loss of voluntary movement in the neck, arms, and hands, and full loss of voluntary movement in the feet and legs. Review of the resident's restorative program showed s/he was to receive bilateral ROM exercises to the upper and lower extremities four times a week to maintain the current ROM level. During an interview on 7/12/06 at 1:25 PM, the resident denied receiving ROM exercises four times a week. Review of the restorative documentation showed the resident received ROM exercises as follows:

a. Three times from April 1 through 7th, three times from April 8 through the 14th, once from April 15th through the 21st, and twice from April

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F 318	Continued From page 15 22nd through the 28th. b. Once from April 29th through May 5th, not at all from May 6th through the 12th, once from May 13th through the 19th, three times from May 20th through the 26th, and once from May 27th through June 2nd. c. Not at all from June 3rd through the 9th, three times from June 10th through the 16th, and twice from June 17th through the 23rd. No therapy was provided from June 24th through July 4th. d. ROM exercises were provided on July 5th, 9th, and 10th. 4. Interview with restorative aide (RA) #1 on 7/13/06 at 10 AM revealed staff tried to complete the restorative program as planned, but sometimes they missed some residents. However, the RA did confirm the accuracy of the restorative documentation; she stated if the program was completed as planned, it was definitely documented.	F 318		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322	F322 Based on the comprehensive assessment the facility will ensure that residents who are fed by an NG or gastrostomy tube receive the appropriate treatment and services to prevent complications and if possible to restore normal eating skills. This will be accomplished by,	

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F 322	Continued From page 16 Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to assure staff administered gastrostomy (tube or enteral) feedings to one (#21) of one sample residents in a manner which assessed the potential for possible complications and which minimized the development of possible complications. The findings were: Observation on 7/11/06 at 7:25 AM revealed resident #21 had a gastrostomy (feeding) tube. According to the 5/15/06 care plan, staff were to "check residual before feeding"; if the residual amount was above 100 milliliters (ml), they were to hold the feeding for one hour, recheck for residual, and administer the feeding only if the amount was below 100 ml. Observation at 11:45 AM showed registered nurse (RN) #3 prepared and administered medications and a can of Isosource VHN (tube feeding) without checking for residual stomach contents or placement of the feeding tube. During an interview immediately after the observation, the RN stated they "do not check for placement" of the resident's feeding tube. The RN further stated she "probably should have checked for residual." Interview with the director of resident care services on 7/12/06 11:45 AM and review of documentation (last revised 3/06) related to the facility's procedure manual revealed they used the "Advanced and Basic Nursing Procedures set down in the Lippincott Williams & Wilkins 'Nursing Procedures, Edition IV.'" Review of the procedure for tube feedings showed "Check placement of the feeding tube to be sure it hasn't slipped out since the last feeding" and "To assess gastric emptying, aspirate and measure residual gastric	F 322	F 322-cont. A. RN #3 will be instructed to follow the written care plan by checking the residual for resident #21 before giving medications or fluids. B. All residents who have NG or gastrostomy tubes have the potential to be affected by the lack of appropriate treatment and services to prevent complications. C. Instruction related to specific resident needs will be placed on the CNA and Nurse Treatment documentation sheets. D. A random documentation audit will be performed on treatment documentation sheets by the MDS/Restorative Director. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council.	8/21/2006

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F 322	Continued From page 17 contents."	F 322		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hazard free environment in one of three soiled utility rooms accessible to residents. The findings were: Observation on 7/11/ 06 at 9:48 AM and again on 7/13/06 at 8:13 AM revealed a cabinet under the sink in the soiled utility room opposite the north nurses' station was not properly locked. The cabinet contained dangerous chemicals including: 1) a spray bottle of antibacterial cleaner. The bottle was labeled "Do Not Drink" and "Corrosive. Contains Ammonium Chloride. Causes irreversible eye damage." 2) a one gallon container of HilPhene. The bottle was labeled with " germicidal detergent. Danger. Causes irreversible eye damage. Harmful if absorbed through the skin. 3) a one gallon bottle of disinfectant bleach. The bottle contained sodium hypochlorite as an active ingredient and was labeled "Harmful if swallowed" . 4) a spray bottle of apple cinnamon odor counteractant. The bottle was labeled "Do Not Drink" and "Eye and Skin Irritant" Interview with Registered Nurse #4 on 7/13/06 at 8:23 AM confirmed the doors to the soiled utility rooms are not locked but "the	F 323	F 323 The facility will ensure that the resident environment will be free of accident hazards. This will be accomplished by, A. All chemicals located in the North and South Soiled Utility Rooms will be removed and stored in the locked housekeeping closets. B. All residents have the potential to be affected by the lack of properly stored chemicals. C. Chemicals will no longer be stored in the cabinets in the Soiled Utility Room. All chemicals will be stored in the locked housekeeping closets and keys will be available from the shift supervisor on each unit. A visual tool will be placed in both soiled utility rooms to inform staff that chemicals are not to be stored in this area.	

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F 323	Continued From page 18 cabinet under the sink should be locked. "	F 323	F 323-cont. D. The MDS/Restorative Director will perform random audits to ensure that there are no chemicals located under the sinks in the soiled utility rooms. Data will be aggregated quarterly and submitted to the Medical Director and Quality Council.	8/21/2006
F 327 SS=D	483.25(j) HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure residents consumed sufficient fluid intake to maintain hydration for two of 17 sample residents (#89, #91). The findings were: 1. Review of the 5/30/06 quarterly Minimum Data Set (MDS) assessment revealed resident #89 required limited assistance for eating. Review of the 2/24/06 nutrition risk assessment showed the resident's estimated fluid needs were 1415 cubic centimeters (cc) per day. Review of the 5/25/06 nutrition assessment showed the resident's average fluid intake with meals was 398 cc. Review of the July 2006 intake record showed the resident's average fluid intake with meals was 651 cc. Review of nursing notes showed on 6/18/06 the resident had a fecal impaction. According to Taber's Cyclopedic Medical Dictionary, edition 19, 2001, fecal impaction may be caused by dehydration. Review of the 2/28/06 dehydration RAP (resident assessment protocol) module showed the resident was at high risk for dehydration related to dementia and contractures of the hands. The module documented the resident required assistance to drink fluids. The	F 327	F 327 The facility will ensure that each resident receives sufficient fluid intake to maintain proper hydration and health. This will be accomplished by, A. All nursing staff will be instructed to offer and encourage resident #89 to drink fluids. A visual tool will be placed in resident #89's room to remind staff to offer fluids. A. Nursing staff will be instructed to give resident #91 thickened liquids with medications and between meals.	

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F 327	Continued From page 19 recommendations included "Encourage resident to drink in between meals, offer often and assist x 1 when needed..." The 5/30/06 care plan showed staff were to encourage the resident to drink between meals and offer fluids often. a. Observation of the resident on 7/11/06 revealed the resident was not offered fluids prior to breakfast (from 7:25 AM until 8:32 AM). The resident did not drink fluids for the breakfast meal. Observation from breakfast until lunch (8:32 AM until 12:15 PM) revealed staff did not offer or encourage fluids. During that time, at 10:35 AM, certified nurse aides (CNAs) # 2 and #3 took the resident to the bathroom and assisted the resident into the wheelchair, but did not offer fluids. According to the meal intake record, the resident refused fluids at the lunch meal. Observation of the resident at the evening meal (on 7/11/06) revealed the resident did not drink any fluids. After the evening meal, CNA #4 took the resident to the bathroom, provided oral care, and put the resident to bed for the night. The CNA did not offer fluids to the resident. b. During an interview on 7/12/06 at 4:15 PM, the MDS/restorative director stated staff should offer fluids between meals and each time they provide care to the residents. 2. Review of the 5/23/06 admission assessment showed resident #91 was dependent on staff for eating. Review of a 6/20/06 nutrition note showed the resident tried to feed himself/herself, and required thickened liquids. Review of a 5/27/06 speech therapy assessment revealed the resident required thickened liquids. Review of the 5/22/06 nutrition risk assessment showed the resident's estimated fluids needs were 1197 cc per day. The 5/22/06 nutrition assessment showed the resident	F 327	F 327-cont. B. All residents have the potential to be affected if they do not receive sufficient fluid intake to maintain proper hydration and health. C. Instruction related to specific resident needs will be placed on the CAN and Nursing treatment documentation sheets. Visual tools will be placed in each resident's room for those identified at risk for dehydration. D. A random visual and documentation audit will be performed on residents and treatment documentation sheets by the MDS/Restorative Director. The Director of Nutritional Services will provide data regarding pre-thickened liquid usage to the MDS/Restorative Director quarterly. Information will be aggregated quarterly and submitted to the Medical Director and Quality Council.	8/21/2006

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F 327	Continued From page 20 only consumed 268 cc at meals. Review of the July 2006 intake record showed the resident's average intake at meals was 590 cc per day. Review of a 5/26/06 laboratory report showed an elevated BUN (blood urea nitrogen) at 27 (normal range is 7-18). According to Taber's Cyclopedic Medical Dictionary, edition 19, 2001, blood urea nitrogen levels may be increased in the presence of dehydration. Review of the 5/23/06 dehydration RAP module revealed CNA charting showed the resident's output exceeded intake. The module documented the resident was not able to drink fluids independently and was at high risk for dehydration. The recommendations included "offer and assist [with] thickened fluids several x [times] ea [each] shift... "The 5/30/06 care plan instructed staff to offer and assist with thickened liquids several times per shift. a. Observation on 7/11/06 revealed at 8 AM, CNAs #5 and #6 assisted the resident out of bed, took the resident to the bathroom, and put the resident in a wheelchair. The resident was not offered fluids. During the breakfast meal (8:25 AM-9 AM), the resident only received one glass of juice (180 cc). The resident drank the juice, but was not offered any more fluids. From 9 AM until 12:15 PM, the resident was not offered fluids. During that time, at 9:50 AM and 11:52 AM, CNAs #5 and #6 provided cares to the resident, but did not offer fluids. Review of the intake record showed the resident only consumed 120 cc at the lunch meal. b. During an interview on 7/12/06 at 4:15 PM, the MDS/restorative director stated staff should offer fluids between meals and each time they provide care to the residents.	F 327		

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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
	535045	A. BUILDING _____ B. WING _____	07/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVNEUE H POWELL, WY 82435

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F 371 SS=D	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 and staff interview, the facility failed to assure outdated liquid supplements were discarded in two of three unit refrigerators. The findings were: Observation on 7/10/06 at 4:48 PM and again on 7/13/06 at 8:12 AM revealed the residents' refrigerator near the south nurse's station contained ten individual servings of "Health Reach" vanilla shakes. The number "610" was written on three cartons; "69" was written on two of them; "617" was written on four of them; and "622" was written on one. The refrigerator near the north nurse's station contained nine individual servings of "Health Reach" vanilla shakes. No writing was found on any of the cartons. Cartons in both refrigerators however were imprinted with a statement stating the shakes were only good for 14 days after thawing. Interview with the dietary manager on 7/13/06 at 9:40 AM revealed the written numbers represented the date the shake was thawed and all cartons should have a date. The dietary manager also stated the shakes were out dated and would be discarded.	F 371	F 371 The facility will ensure that food will be stored, prepared, distributed and served under sanitary conditions. This will be accomplished by, A. Nutrition staff will inventory all supplies in the pantries and discard all out of date products. B. All residents have the potential to be affected by practices which do not provide for food to be stored, prepared, distributed and served under sanitary conditions. C. The Nutritional Services Director will pull all shake cartons from the freezer and label each carton with a thaw date and a use by date. All nutrition staff will be in-serviced regarding the dates and the need to discard out of date cartons when making daily rounds.	

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F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS 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 interviews, the facility failed to assure a physician or midlevel practitioner visit occurred at least once every 60 days as required for two (#21, #26) of 17 sample residents. The findings were: 1. Review of physician documentation showed lack of physician visits for resident #21 from 3/8/05 until 9/27/05 (over 6 and 1/2 months) and from 9/27/05 until 5/2/06 (over seven months). Review of the medical record failed to show evidence of any other visits. After reviewing the medical record and checking with the physician's office, director of nursing service #1 verified, on 7/12/06 at 2 PM, that the aforementioned dates for physician visits were correct. Interview with the director of resident care services on 7/12/06 at 3:53 PM confirmed no physician or midlevel practitioner saw the resident between the above itemized dates. 2. Review of physician documentation showed lack of physician visits for resident #26 from 6/8/05 until 9/2/05 (2 and 3/4 months apart), from 11/16/05 until 3/2/06 (over 3 and 1/2 months),	F 387	F 371-cont. D. The Nutritional Services Director will perform random audits of food stock to determine compliance with out of date items. The information will be aggregated and reported to the Medical Director and Quality Council quarterly. F387 The facility will ensure that residents are seen by a physician at least every 30 days for the first 90 days following admission and then at least every 60 days thereafter. This will be accomplished by, A. The primary physician for resident #21 will be notified by the medical director of the requirement to see the resident as scheduled A. The primary physician for resident # 26 will be notified by the Medical Director of the requirement to see the resident as scheduled. The resident's last visit was within the last 60 days.	8/21/2006

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F 387	Continued From page 23 and from 3/30/06 through 7/12/06 (over 3 and 1/2 months). Interview with the director of resident care services on 7/12/06 at 3:53 PM confirmed no physician or midlevel practitioner saw the resident between the indicated dates.	F 387	F387-cont. B. All residents have the potential to be affected by failing to assure that a physician or midlevel practitioner visit occurs as scheduled. C. The Director of Resident Services will provide each individual physician a schedule quarterly which indicates which of his or her residents need to be seen. D. Data will be aggregated and a percentage of compliance will be determined. The information will be submitted to the Medical Director and the Quality Council.	8/21/2006