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

PRINTED: 11/13/2009
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 _____	11/05/2009

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

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F 278 SS=E	483.20(g) - (j) 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 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the Resident Assessment Protocols (RAPs) were completed prior to the registered nurse (RN) certifying the completion of the Resident Assessment Instrument (RAI) for 14 of 17 sample residents (#9, #13, #19, #20, #27, #32, #34, #61, #62, #66,	F 278	F278 The facility will ensure that the Resident Assessment Protocols (RAPS) are completed prior to the registered nurse (RN) certifying the completion of the Resident Assessment Instrument (RAI). A. The RAP should have been completed prior to RAI certification. Due to the nature of the error, the record cannot be corrected at this late date for Resident #9, #13, #19, #20, #27, #32, #34, #61, #62, #66, #78, #81, #93, and #96. B. All residents have the potential to be affected by an assessment that does not accurately reflect the resident's status. C. The MDS Director will provide education to the Interdisciplinary Team regarding deadlines for RAP's. The MDS Director will perform an audit weekly to ensure that all RAPs were completed prior to date the RAI was certified as completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 12-15-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Dept of Health

POC approved at 1650 on 12-15-09 by telephone voice message to Cheri Benander, DOW. Jean Mohr 12-15-09

DEC 15 2009
Office of Healthcare Licensing and Surveys

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F 278	Continued From page 1 #78, #81, #93, #96). The findings were: According to the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, Revised December 2008, page 1-24, "...An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment." 1. Review of the following RAIs revealed some RAPs were signed and dated after the VB2 date: a. The 8/31/09 RAI for resident #96. b. The 12/22/08 RAI for resident #93. c. The 1/12/09 RAI for resident #78. d. The 7/20/09 RAI for resident #81. e. The 4/20/09 RAI for resident #19. f. The 12/22/08 RAI for resident #9. g. The 12/1/08 RAI for resident #13. h. The 12/15/08 RAI for resident #20. i. The 12/1/08 RAI for resident #61. j. The 8/3/09 RAI for resident #62. k. The 2/23/09 RAI for resident #66. l. The 8/3/09 RAI for resident #27. m. The 2/23/09 RAI resident #32. n. The 4/20/09 RAI for resident #34. 2. During an interview on 11/4/09 at 4:20 PM, the MDS coordinator stated the RAPs should be completed by the date at VB2, and should not be completed after that date.	F 278	F278 cont. D. The MDS Director will aggregate the data and report the results monthly to the VP of Resident Care Services, the Care Center Medical Director, and Quality Council. The Quality Council will have the overall responsibility to ensure the facility is in compliance.	12/18/2009
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281	F281 The facility will ensure that professional standards are followed in regards to physician's orders. A. All nursing staff will be instructed to follow physician's orders for oxygen therapy for resident # 66 ensuring professional standards B. All residents have the potential to be affected by the failure to follow professional standards and ensuring that physician orders are followed.	

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F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 2 Based on observation, medical record review, and staff interview, the facility failed to ensure professional standards were followed related to following physician's orders for 1 of 17 sample residents (#66). The findings were: Review of the November 2009 physician's orders for resident #66 showed an order for oxygen to keep the saturation level (O2 Sat) at or above 90%. During an observation on 11/3/09 at 9:30 AM, the resident was in a recliner chair across from the north nurse's station. The resident's nasal cannula for oxygen was connected to wall oxygen, but the oxygen was not turned on. The resident remained without supplemental oxygen until 10:45 AM (1 hour and 15 minutes). At that time licensed practical nurse (LPN) #1 performed an O2 Sat level on the resident at the request of the surveyor, which revealed a reading of 87%. The nurse then turned on the resident's oxygen. Interview with LPN #1 at that time revealed she expected staff to keep the resident's supplemental oxygen on at all times. Review of the Wyoming Nurse Practice Act of July 2005, pages 3-6 documented nurses must practice under the direction of a physician.	F 281		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility's freezer was	F 465	F 465 The facility will ensure a safe, functional, sanitary, and comfortable environment for staff by maintaining the freezers in a manner to prevent ice accumulation on the ceiling and floor. A. The Maintenance Technician shall schedule shutting down and defrosting the freezer. Additionally the Technician shall check the freezer for proper operation. B. All staff has the potential to be affected by the failure to maintain the freezers in safe manner.	

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F 465	Continued From page 3 maintained in a manner to prevent ice accumulation on the ceiling and floor. The findings were: Observations on 11/2/09 at 4:30 PM and then again on 11/4/09 at 9:45 AM revealed an approximate 3 square foot by 2 inch thick accumulation of ice on the ceiling of the facility walk-in freezer. The ice was directly over several open boxes of shelved frozen food. In addition, there were approximately 5 small (1-2 square inch) pieces of ice on the floor in the aisle. Interview with the facility's administrator on 11/4/09 at 4:48 PM confirmed the presence of the ice on the ceiling and floor. The administrator also stated he was unaware of the ice formation.	F 465	F465 cont. C. Nutritional Services will perform a random visual audit monthly in the freezer to ensure that the area is safe for employees D. The Nutritional Services Director will aggregate the data and report the results monthly to the VP of Resident Care Services, the Care Center Medical Director, and Quality Council. The Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff maintained an accurate medical record for 1 of 20 sample residents (#32). The findings were:	F 514	F514 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. A. The physician will be notified and a clarification will be made to determine if the resident is hyperkalemia or hypokalemia and a note will be entered into the chart for resident #32.	12/18/2009

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F 514	Continued From page 4 Review of the medical record for resident #32 revealed the monthly dietary care plan listed several diagnoses including hyperkalemia (high potassium blood levels). However, review of the physician notes revealed the resident was diagnosed with chronic obstructive pulmonary disease (COPD) and hypertension for which the resident was prescribed Lasix 20 milligrams per day. According to the 2005 edition PDR Nurses Drug Handbook, Lasix is a non-potassium sparing diuretic, i.e., increases the excretion of sodium chloride and to a certain extent potassium. Due to the risk of potassium loss (hypokalemia), the resident was also prescribed potassium chloride 20 milliequivalent per day. Review of the resident's lab levels for potassium revealed normal levels except for one occasion (1/20/09) when the potassium level was below normal (hypokalemia). Interview with DON #1 on 11/4/09 at 3:48 PM revealed the resident did not have hyperkalemia but rather due to the diuretic, was at risk for developing low blood potassium levels, i.e., hypokalemia. The DON also stated listing hyperkalemia on the dietary care plan was a mistake.	F 514	F514 cont. B. All residents have the potential to be affected by the failure to maintain and accurate medical record. C. The MDS Director will provide education to the Interdisciplinary Team to ensure that team members understand where to locate current and historical data and the importance of proof reading documentation. The Nutrition Director will perform a random audit of resident charts monthly to ensure that the dietary care plan accurately reflects the residents' diagnosis. D. The Nutrition Director will aggregate the data and report the results monthly to the VP of Resident Care Services, the Care Center Medical Director, and the Quality Council. The Quality Council will have the overall responsibility to ensure the facility is in compliance.	12/18/2009