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 _____	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER 307754 2267	777 AVENUE H POWELL, WY 82435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set mg- milligrams RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F 167** The facility shall ensure the most recent survey results are identified as available for examination by the residents. 1. a. The holder mounted on the wall was marked with a clearly identifiable label titled "Survey Results" prior to the Survey exit. The residents will be informed of this change during the upcoming Resident Council meeting on May 21, 2014. b. All residents have the potential to be affected by failure to ensure that the survey results are clearly identifiable for residents to examine c. The Social Services/Recreation Director or designee will complete ongoing monthly observations to ensure the survey results are clearly identifiable for residents. d. The Social Services/Recreation Director or designee will aggregate monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interviews, the facility failed to ensure the most recent survey results were identified as available for examination by the residents. The findings were: During a confidential resident meeting on 4/22/14	F 167		06/06/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Nicole Osterhiller BSN, RN — Administrator — 6/1/14

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

6/10/14

The POC was accepted 6/10/14. The DON was left a VM 6/13/14@ 11AM — Connie Chapman RN

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 at 1 PM two residents stated they were not aware of the location of the most recent survey results. Further, the residents indicated they would like the opportunity to examine the write-up. During an interview and observation with the social worker on 4/22/14 at 2:15 PM, she acknowledged the survey results, located in an unmarked rack mounted on the wall, were not clearly identifiable.	F 167	**F 241** The facility shall promote care for residents that maintains or enhances dignity 1. a. The urine drainage bag for resident # 41 was placed in a cover to maintain dignity. All urine drainage bags will be placed inside a cover to maintain dignity. b. All residents have the potential to be affected by failure to ensure that the resident's dignity is maintained and or enhanced. c. All nursing staff will be educated regarding the need to maintain resident's dignity by covering urine drainage bags. The Care Center Nursing Director or designee will complete ongoing monthly observations to ensure urine drainage bags are covered to provide dignity. d. The Care Center Nursing Director or designee will aggregate monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure dignity was maintained for 1 of 14 sample residents (#41). The findings were: Review of the 2/25/14 quarterly MDS assessment showed resident #41 had diagnoses to include neurogenic bladder and the resident had an indwelling catheter (tube inserted in the bladder for urine drainage). Further, the assessment showed the resident was totally dependent on staff for transfers. Observation on 4/22/14 at 12:25 PM showed the resident self-propelled him/herself down the hallway in an electric wheelchair with the catheter bag attached to the side of the chair. The bag was uncovered exposing the resident's urine. Observation on 4/23/14 at 7:45 AM showed the urine drainage bag remained uncovered while the resident was	F 241	Completion Date	06/06/2014

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2 in the hallway. During an interview with RN #2 at that time, she acknowledged the drainage bag needed to be covered.	F 241	**F 253** The facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. 1a. a. All recessed light fixtures will be cleaned to remove insects and debris including the main hallway, North hallway and foyer to the main dining room. b. All residents, staff, and visitors have the potential to be affected by failure to maintain the lighting free of insects and debris and ensure a clean environment. c. The Plant Operations Director or designee will perform ongoing monthly audits to ensure the light fixtures are clean as evidenced by the absence of insects and debris. d. The Plant Operations Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedures, and staff interview, the facility failed to maintain a clean and sanitary environment for residents in 2 of 4 units and in the main hallway and dining room area. The findings were: 1. Tour of the facility on 4/23/14 revealed the following concerns: a. Observation on 4/23/14 at 10:30 AM revealed 13 of 27 recessed light fixtures in the main hallway were dirty with dead insects and debris. Continued tour of the facility on the same day from 10:35 AM to 10:55 AM showed 2 of 2 light fixtures in the North hallway, 1 of 1 light fixtures in a foyer leading to the main dining room, and 4 of 14 light fixtures in the dining room were similarly dirty with dead insects and debris. b. Observation on 4/23/14 at 11 AM at the nurses' station in the secure care unit (SCU) showed two edges of the work surface were delaminated and exposed a porous, non-cleanable surface. c. Observation on 4/23/14 at 11:30 AM revealed 3 of 4 privacy curtains in the North tub	F 253	Completion Date	06/06/2014

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 3 room were visibly soiled and stained. d. Observation on 4/23/14 at 11:30 AM revealed 2 of 6 sprinkler heads were coated with dust and debris in the North tub room, 1 of which was over a resident care area, i.e. tub. The housekeeping supervisor stated in an interview on 4/24/14 at 8:30 AM that light fixtures were scheduled for cleaning once each year. She confirmed the fixtures were dirty and needed to be cleaned; she further acknowledged that annual cleaning for the light fixtures was not sufficient. The maintenance supervisor confirmed in an interview on 4/24/14 at 10:15 AM that the work surface at the nurses' station in the SCU was damaged, and the underlying surface was not sealed; the porous material could not be effectively cleaned and disinfected. 2. Observation of an intermittent urinary catheterization for resident #50 on 4/22/14 at 10:40 AM showed RN #1 cleansed the resident with povidone-iodine (a brown antiseptic cleanser) in preparation for the catheterization. After the catheterization was complete, RN #1 grasped and opened the privacy curtains with visibly soiled gloves, took the resident's urine into the bathroom, then returned and grasped the privacy curtains from the other side using the same visibly soiled gloves. The privacy curtains for both the A and B beds were visibly soiled with a brownish colored stain. Observation on 4/23/14 at 11 AM with the DON verified the privacy curtains in resident #50's room were visibly stained with a brownish color that, "looks like betadine [povidone-iodine]." The DON also	F 253	**F253 Cont.** 1b. a. All delaminated surfaces and including the surfaces in the special care unit will be replaced with new laminate. Staff will be instructed to submit maintenance work orders for replacement of any surfaces that become delaminated. b. All residents, staff, and visitors have the potential to be affected by failure to ensure surfaces are cleanable and to maintain a sanitary environment. c. Staff will be educated to submit maintenance work orders for replacement of any delaminated surfaces. The Plant Operations Director or designee will perform ongoing monthly visual inspections to ensure there are no exposed surfaces. d. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 06/06/2014	

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 verified the curtains should have been cleaned. Review of facility policy and procedure entitled, "Daily cleaning of resident rooms", dated January 2014 showed, "9. Be certain to check privacy curtains for stains, if resident has occupied room more than six months remove curtains and launder."	F 253	**F253 Cont.** 1c. a. The privacy curtains in the North tub room have been laundered. The housekeeping staff will check privacy curtains for soiling or stains daily and launder any of the curtains found to be dirty. Housekeeping staff will also remove curtains and launder them no less than every 6 months. All staff will be instructed to notify housekeeping when privacy curtains become visible soiled or stained. b. All residents, staff, and visitors have the potential to be affected by failure to ensure that privacy curtains are kept clean and free from stains. c. Housekeeping staff will be educated to check privacy curtains daily and launder if found to be dirty. They will also be educated that curtains must be laundered at least every 6 months. Nursing staff will be educated regarding the need to notify housekeeping when privacy curtains become stained or soiled. The Housekeeping Supervisor or designee will perform ongoing monthly	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure staff provided care in accordance with the written plans of care for 2 of 14 sample residents (#8, #41). The findings were: 1. Review of the current care plan (last updated by staff on 4/15/14) showed staff were instructed to provide extensive assistance with meals for resident #8. The following observations showed staff did not provide the assistance required for 2 of 3 meals: a. Observation on 4/22/14 at 8:40 AM showed the resident was in the dining room. The resident had two mugs with a spout lid in front of him/her. Continued observation until 9:10 AM showed no staff sat next to the resident, nor did any staff provide cueing or physical assistance with the meal. During the observation, the resident	F 282		6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 occasionally put the mugs to his/her mouth. At 9:10 AM, CNA #2 took the lids off the mugs; one cup contained milk, and the other hot cereal. Both mugs were almost full. At 9:22 AM, after receiving no staff assistance for the meal, the resident was removed from the dining room. b. Observation on 4/22/14 at 12:01 PM revealed the resident was in the dining room. A mug with a spout lid, containing a strawberry drink, was put in front of the resident. At 12:06 PM the resident was given two mugs with spout lids. At 12:15 PM, CNA #3 sat next to the resident. She provided occasional cueing, and put the mug to the resident's mouth a few times until she left at 12:24 PM. The resident received no staff assistance or cueing until 12:40 PM when CNA #4 sat next the resident. The CNA cued the resident to drink, but the resident did not drink any further. At 12:55 PM the CNA took off the lids to the mugs and saw that one mug contained pureed spaghetti with meat sauce, and the other pureed vegetables. The consistency was too thick to enable the resident to have consumed from the mugs. The CNA then used a spoon to try and feed the resident the pureed food, but the resident only took a few bites. The resident was removed from the dining room at 1 PM. During an interview on 4/23/14 at 4:14 PM the administrator confirmed the resident required extensive assistance with meals. 2. Review of the 2/19/14 photographic wound documentation sheet showed resident #41 had a stage II pressure ulcer. The pressure ulcer was located on the left buttock over the ischial tuberosity and measured 0.5 centimeters (cm) by 1.0 cm. Review of the skin care guide initially dated 2/19/14 showed documentation was to be	F 282	**F253 Cont.** visual audits to ensure that privacy curtains are free from soil and stains. d. The Housekeeping Supervisor or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 1d. a. All sprinkler heads and including the North tub room have been dusted and cleared from debris. b. All residents, staff, and visitors have the potential to be affected by failure to ensure sprinkler heads are free from dust and debris and to maintain a sanitary environment c. The Plant Operations Director or designee will perform ongoing monthly visual audits to ensure sprinkler heads are free from dust and debris. d. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 completed weekly and as needed related to the condition of the wound. Further review of the skin care guide and photographic wound documents failed to show further documentation was completed related to the appearance of the wound until 4/4/14. At that time, the photographic wound document showed the wound measured 3.5 cm by 4.1 cm. An interview with the DON on 4/24/14 at 8:30 AM confirmed the wound needed to be monitored weekly as indicated on the skin care guide.			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide assistance at meals to maintain good nutrition for 1 of 4 sample residents (#8) who required extensive assistance or were dependent with eating. The findings were: Review of the 1/14/14 annual MDS assessment revealed resident #8 required extensive assistance for eating. According to the 4/9/14 nutrition assessment, the resident required extensive assistance with eating and required frequent/constant cueing. Review of the current care plan (last updated by staff on 4/15/14) showed staff were instructed to provide extensive		**F253 Cont.** Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 06/06/2014 2. a. The housekeeping staff will check privacy curtains for soiling or stains daily and launder any of the curtains found to be dirty. Housekeeping staff will also remove curtains and launder them no less than every 6 months. All staff will be instructed to notify housekeeping when privacy curtains become visible soiled or stained. b. All residents, staff, and visitors have the potential to be affected by failure to ensure that privacy curtains are kept clean and free from stains. c. Housekeeping staff will be educated to check privacy curtains daily and launder if found to be dirty. They will also be educated that curtains must be laundered at least every 6 months. Nursing staff will be educated regarding the need to notify housekeeping when privacy curtains become stained or soiled. The Housekeeping Supervisor or designee will	6/10/14 ab

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 assistance with meals. The following observations showed staff did not provide the assistance required for 2 of 3 meals: a. Observation on 4/22/14 at 8:40 AM showed the resident was in the dining room. The resident had two mugs with a spout lid in front of him/her. Continued observation until 9:10 AM (30 minutes) showed no staff sat next to the resident, nor did any staff provide cueing or physical assistance with the meal. During the observation, the resident occasionally put the mugs to his/her mouth. At 9:10 AM, CNA #2 took the lids off the mugs; one cup contained milk, and the other hot cereal. Both mugs were almost full. At 9:22 AM, after receiving no staff assistance for the meal, the resident was removed from the dining room. b. Observation on 4/22/14 at 12:01 PM revealed the resident was in the dining room. A mug with a spout lid, containing a strawberry drink, was put in front of the resident. At 12:06 PM the resident was given two mugs with spout lids. At 12:15 PM, CNA #3 sat next to the resident. She provided occasional cueing, and put the mug the resident's mouth a few times until she left at 12:24 PM. The resident received no staff assistance or cueing until 12:40 PM when CNA #4 sat next the resident. The CNA cued the resident to drink, but the resident did not drink any further. At 12:55 PM the CNA took off the lids to the mugs and saw that one mug contained pureed spaghetti with meat sauce, and the other pureed vegetables. The consistency was too thick to enable the resident to have consumed from the mugs. The CNA then used a spoon to try and feed the resident the pureed food, but the resident only took a few bites. The resident was removed from the dining room at 1 PM. During an interview on 4/23/14 at 4:14 PM the	F 312	**F253 Cont.** perform ongoing monthly visual audits to ensure that privacy curtains are free from soil and stains. d. The Housekeeping Supervisor or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date **F 282** The facility shall ensure staff provides care in accordance with the written plan of care. 1. a. All nursing staff will be instructed to follow the plan of care for resident # 8 which states, "Provide extensive assistance for eating." b. All residents have the potential to be affected by not providing care in accordance with the resident's individualized plan of care. c. All nursing staff will be educated on the importance of following the residents plan of care in the May staff meetings. The Care Center Nursing Director or	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8 administrator confirmed the resident required extensive assistance with meals. On 4/24/14 at 9:26 AM the DON stated he was not sure why staff was putting the resident's pureed food into mugs.	F 312	F282 Cont. designee will perform ongoing monthly audits to ensure that all services provided by staff are in accordance with the plan of care.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide the necessary services to promote healing for 1 of 1 sample residents (#41) with a pressure ulcer. The facility failed to monitor and assess the pressure ulcer, which worsened from a stage II to a stage IV resulting in harm for this resident. In addition, the facility failed to consistently implement interventions to prevent pressure ulcers for 1 of 8 sample residents (#39) who were at risk for the development of pressure ulcers. The findings were: 1. Review of the 11/26/13 annual MDS assessment showed resident #41 had diagnoses to include multiple sclerosis and required extensive assistance with bed mobility. Further,	F 314	d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. Completion Date a. All nursing staff will be instructed to follow the plan of care and skin care guide for resident #41 which states, "Complete and document treatment on the Treatment Administration Record. Complete weekly and PRN progress note on condition." The skin care guide will be revised to specify that the weekly progress note should include an assessment of the wound with a description of the skin problem to include the location, size, wound bed appearance, exudate and any pain.	06/06/2014 6/10/14 cc

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9 the care area assessment (CAA) for pressure ulcers showed the resident had a previous history of pressure ulcers. Review of the Braden Scale (tool used to determine the risk for developing pressure ulcers) showed the resident's score was 12, indicating a high risk for developing pressure ulcers. Review of the 2/19/14 photographic wound document sheet showed s/he had developed a stage II pressure ulcer. The pressure ulcer was located on the left buttock over the ischial tuberosity and measured 0.5 centimeters (cm) by 1.0 cm. Review of the nurse's notes dated 2/19/14 and timed 3:33 PM indicated a wound assessment was completed and the physician had been notified. The following concerns were identified: a. The nurse's note dated 4/4/14, timed 6 AM, showed the CNA had reported; "the wound on [his/her] buttock appeared larger, have pus and is bleeding." The note did not indicate the wound had been assessed at that time. Further review showed a nurses' note dated that same day, timed 7:22 PM, (13 hours, 22 minutes later) which indicated a wound assessment had been completed and showed the resident's "left tuberosity is completely opened red with some weeping and purulent discharge." Photographs and measurements were taken of the wound for the wound care nurse. Review of the nurses' notes from 2/20/14 through 4/3/14 (43 days) failed to show documentation concerning the appearance of the wound, including wound measurements until 4/4/14. b. Review of the photographic wound document dated 4/4/14 showed the wound measured 3.5 cm by 4.1 cm with a depth of 0.1 cm and showed it remained a stage II pressure ulcer. Neither the nurse's note nor the wound document, indicated the physician had been	F 314	**F282 Cont.** b. All residents have the potential to be affected by not providing care in accordance with the resident's individualized plan of care. c. All nursing staff will be educated on the importance of following the residents plan of care and to complete an assessment of the wound with a weekly and PRN progress note to include a description of the location, size, wound bed appearance, exudate and any pain in the May staff meetings. The Care Center Nursing Director or designee will perform ongoing monthly audits to ensure that all services provided by staff are in accordance with the plan of care. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014 6/10/14 ae

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 notified of the progression of the wound. c. Review of the nurse's note dated 4/9/14, timed 5:10 PM, revealed the wound had "deteriorated since previous assessment on 4/4/14." Further, the wound measured 5.5 cm by 4.0 cm and 2.5 cm deep with undermining of 4 cm (wound diameter is wider at the base than at the wound's skin edge). The 4/9/14 photographic wound document showed the wound was a stage IV pressure ulcer and that bone was evident. Review of the Physician Communication sheet dated 4/9/14 showed the physician was notified and wound care instructions were ordered. d. During an interview with the DON and wound care nurse on 4/24/14 at 10:25 AM revealed they would have expected documentation to show the resident's wound had been assessed weekly and that there was ongoing communication with the physician after the development of the stage II pressure ulcer. 2. Review of the 12/31/13 annual and 4/1/14 quarterly MDS assessments showed resident #39 was at risk for pressure ulcers. The assessments further indicated a pressure reducing device was used in the chair. According to the 3/31/14 Braden Scale, the resident was at moderate risk for pressure ulcers due to slightly limited sensory perception, slightly limited mobility, and chairfast (spending most of the time in a chair). The following concerns were identified: a. Observation of the resident on 4/22/14 at the following times revealed s/he was in a wheelchair with no cushion: 7:55 AM to 9:25 AM, 12 noon to 1:05 PM, and at 5:25 PM. b. Observation on 4/23/14 at 9:10 AM revealed the resident was seated on a cushion in the wheelchair. During an interview on 4/23/14 at 10 AM, CNA #5 stated the resident usually had a	F 314	**F 312** The facility shall ensure staff provides assistance at meals to maintain good nutrition. 1. a. All nursing staff will be instructed to follow the plan of care for resident # 8 which states, "Provide extensive assistance for eating." b. All residents have the potential to be affected by not providing care in accordance with the resident's individualized plan of care. c. All nursing staff will be educated on the importance of following the residents plan of care in the May staff meetings. The Care Center Nursing Director or designee will perform ongoing monthly audits to ensure that all services provided by staff are in accordance with the plan of care. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014 6/10/14 DC

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 cushion in the wheelchair, and was not sure why the cushion was not used on 4/22/14. c. On 4/23/14 at 4:45 PM the DON stated the cushion should have been in the wheelchair the day before (4/22/14). He stated all residents who could not walk and were in a wheelchair should have a cushion.	F 314	**F 314** The facility shall ensure staff provides the necessary services to promote healing for residents with a pressure ulcer. 1a. a. All nursing staff will be instructed to follow the plan of care and skin care guide for resident #41 which states, "Complete and document treatment on the Treatment Administration Record. Complete weekly and PRN progress note on condition." The skin care guide will be revised to specify that the weekly progress note should include an assessment and documentation of the description of the skin problem to include the location, size, wound bed appearance, exudate and any pain. All nursing staff will be instructed to notify the physician with any progression of a pressure ulcer wound for resident # 41 and all residents. b. All residents have the potential to be affected by not providing care in accordance with the resident's individualized plan of care.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of facility policy and procedures, the facility failed to ensure measures were utilized for the prevention of urinary tract infections (UTIs) for resident #41 and #50 during 3 of 3 random observations. The findings were: 1. Review of the medical record showed resident #50 was admitted to the facility on 11/10/09 with diagnoses including urinary retention and neurogenic bladder. Review of the medical record further revealed the resident had a physician's order dated 2/22/12 for nursing staff to perform intermittent urinary catheterizations 4 times daily.	F 315		6/10/14 OC

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 Review of the care plan updated on 2/28/14 showed the resident required intermittent urinary catheterizations. Interventions included maintaining, "strict sterile technique throughout the process." In addition, goals included the, "opportunity for urinary tract infection will be minimized." The following concerns were identified: a. During an observation of a urinary catheterization for the resident on 4/22/14 at 10:40 AM, RN #1 opened the sterile catheter kit and prepared the sterile contents with bare hands, touching and contaminating the sterile contents of the insertion kit. The RN placed a barrier under the resident's perineal area with bare hands and noticed the resident had been incontinent of bowel. The RN applied gloves and assisted CNA #1 clean the patient of loose, brown stool. The RN removed her gloves but did not wash her hands then proceeded to apply the sterile gloves contained in the catheter insertion kit. She applied the sterile gloves touching and adjusting the fit of the gloves with bare hands. The RN cleansed the resident's urinary meatus (urinary opening) with betadine saturated cotton balls from the opening down toward the buttocks 3 times; the residents labial folds were not held apart with the nurse's nondominant hand. After the catheterization was complete, RN #1 continued to wear the same visibly soiled gloves and opened the privacy curtains to empty the residents urine, then re-opened the privacy curtains with the same visibly soiled gloves. b. Additional observation on 4/22/14 at 4:05 PM with LPN #1 revealed she cleansed the resident's urinary meatus downward toward his/her buttocks 4 times. The LPN lubricated and inserted the catheter, however, no urine was returned and the catheter was removed. The LPN then removed	F 315	**F314 Cont.** c. All nursing staff will be educated on the importance of following the residents plan of care, need to notify the physician with any progression of pressure ulcer wound, and to complete an assessment of the wound with a weekly and PRN progress note to include a description of the location, size, wound bed appearance, exudate and any pain in the May staff meetings. The Care Center Nursing Director or designee will perform ongoing monthly audits to ensure that all services provided by staff are in accordance with the plan of care. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. Completion Date a. Staff will be instructed to ensure resident # 39 has a cushion in place in his wheelchair at all times. Staff will also be instructed	06/06/2014

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13 her gloves, washed her hands and opened another sterile catheter insertion kit and catheter. The LPN removed the sterile gloves from the kit and applied them, however, sterility was compromised when bare hands touched the surface of the gloves to position and adjust the gloves fit. The nurse cleansed with betadine saturated cotton balls from the urinary meatus down toward the buttocks 3 times and inserted the lubricated catheter, however, no urine was returned and the catheter was removed. The LPN attempted a third time, however, no new sterile cath insertion kit was opened and the resident's urethral opening was not cleaned at all. c. Review of the resident's medical record showed the resident had a urine culture completed on 12/17/13 and was treated with oral antibiotics for a UTI. d. Interview with the DON on 4/23/14 at 11 AM revealed he expected staff to follow the facility's policy and procedure for inserting urinary catheters and maintain sterile technique. e. Review of the facility's procedure for urinary catheter insertion showed the facility followed, "Lippincott, Williams & Wilkins Nursing Procedures, 5th edition." The following instructions for insertion were listed, "A urinary catheter is inserted using sterile technique...should be performed with extreme care and caution to prevent injury and infection...perform hand hygiene and put on gloves. To create a sterile field open the prepackaged kit and place it between the patient's legs. If the sterile gloves are the first item on top of the tray , put them on...Take care not to contaminate your gloves...Separate the labia majora and labia minora as widely as possible with the thumb, middle and index fingers of your nondominant hand so you have a full view	F 315	**F314 Cont.** to ensure all pressure ulcer prevention measures are carried out according to the plan of care. b. All residents have the potential to be affected by failure to provide the necessary services to promote healing for pressure ulcers c. All nursing staff will be educated on the need to ensure a cushion is placed in resident # 39's wheelchair and all residents with cushions per the plan of care at all times. They will also be educated to carry out all pressure ulcer prevention measures according the each resident's plan of care. Nursing Director or designee will perform ongoing monthly audits to ensure that staff provides the necessary services to promote healing for residents with a pressure ulcer. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall	6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 14 of the urinary meatus. Keep the labia's well separated through the process..so they don't contaminate the area when it's cleaned. With your dominant hand wipe [the cotton ball saturated with betadine] one side of the the urinary meatus with a downward motion...Wipe the other side in the same way. Then wipe directly over the meatus with another sterile applicator or cotton ball. Take care not to contaminate your sterile glove...If the catheter is inadvertently inserted into the vagina, leave it there as a landmark. Then begin the procedure over again using new supplies...Dispose of all used supplies...remove you gloves and discard. Perform hand hygiene." 2. Observation on 4/23/14 at 7:45 AM showed resident #41 sat in a wheelchair located in the hallway. The resident had an indwelling catheter (tube inserted in the bladder for urine drainage) with the bag hanging from the side of the wheelchair at waist level. Further, the tube draining the bladder was looped below the bag and did not allow the urine to flow into the bag. Interview with RN #2 at that time confirmed the tube was not properly positioned to promote urine drainage from the bladder. According to Perry, Potter and Elkin. Nursing Interventions and Clinical Skills, 5th Edition; 2012, regarding positioning an indwelling catheter; "Check to make sure that there is no obstruction to urine flow. Coil excess tubing..." Further; "Keeping the drainage bag below the level of the bladder reduces the risk for CAUTI [catheter associated urinary tract infections]."	F 315	**F314 Cont.** responsibility to ensure the facility is in compliance. **F 315** Completion Date The facility shall ensure measures are utilized for the prevention of urinary tract infections for residents. 1. a. RN # 1 & LPN # 1 will be reeducated regarding strict sterile techniques when performing intermittent urinary catheterizations for resident # 50 per the facility procedure provided by Lippincott, Williams & Wilkins Nursing Procedures, 5th edition. b. All residents have the potential to be affected by the failure to ensure measures are utilized for the prevention of urinary tract infections c. All nursing staff will be educated regarding strict sterile techniques when performing intermittent urinary catheterizations for resident # 50 and all residents per the facility procedure provided by Lippincott, Williams & Wilkins Nursing Procedures, 5th edition. Sterile technique for urinary catheterization	06/06/2014
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

6/10/14 ca

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 15 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure residents were free from significant medication errors during 1 of 2 observed medication passes, affecting residents #46 and #70. This systems failure resulted in harm for resident #70. The findings were: 1. Observation of a medication administration pass on 4/23/14 at 3:37 PM with LPN #1 revealed resident #70 was administered phenobarbital (medication used to prevent seizures) 32.4 mg. The following concerns were identified: a. Review of the April 2014 MAR showed the resident was supposed to receive phenobarbital 32.5 mg twice daily and 32.4 mg 1.5 tablets (dose =48.6 mg) at bedtime, ordered on 10/28/10. Review of an electronically signed physician's progress note dated 3/20/14 with current medications listed showed another dose, "1. Phenobarbital 30 mg in the morning, 30 mg in the evening, 45 mg at bedtime". In addition, the "Physician Orders" dated March, 2014 showed the resident was supposed to receive, "phenobarbital 32.5 mg twice daily for seizure disorder". b. Review of the medical record showed a nursing progress note dated 4/18/14 revealed the CNA had been performing pericare for the resident and the resident had a seizure that lasted approximately 4 minutes. Interview with the pharmacist on 4/24/14 at 10:25	F 333	**F315 Cont.** will be added to the annual nursing skills fair. The Care Center Nursing Director or designee will perform ongoing monthly audits to ensure that measures are utilized for the prevention of urinary tract infections. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 2. a. The nursing staff will be instructed to ensure that all residents with catheters including resident # 41 catheter bag is free from obstruction, coils in excess tubing and that the drainage bag is below the level of her bladder to prevent risk of CAUTI. b. All residents have the potential to be affected by failure to ensure measures are utilized for the prevention of urinary tract infections	06/06/2014 6/10/14 ae

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 16 AM revealed phenobarbital was not available in 32.5 mg, however, it was available in 32.4 mg. The pharmacist was not aware of the physician's progress note that listed the phenobarbital dose as 30 mg twice a day and 45 mg at bedtime. The pharmacist verified the medication dose should have been clarified and the MAR dose should have matched the dose that was given to the patient. Interview with the administrator at the same time verified medication reconciliation was performed by nursing staff on a month to month basis and medications listed on the MAR were compared with physician orders for accuracy. 2. Observation of a medication administration pass on 4/23/14 at 3:50 PM with LPN #1 revealed resident #46 was administered carvedilol 6.25 mg (a medication that lowers heart rate and is used to treat heart failure and high blood pressure). The resident was also administered Lyrica 100 mg (used to treat neuropathy), Symbicort 160-4.5 mcg/act 2 inhalations for chronic obstructive pulmonary disease, and Ditropan 5 mg used to treat urinary urgency. The following concerns were identified: a. Review of the April 2014 MAR showed the patient received carvedilol, Ditropan and Symbicort two times daily in the AM and PM, and the Lyrica was given 4 times daily AM, Noon, PM, and bedtime. There were no specific times recorded when the medication had been administered. LPN #1 was unable to verify the time the AM medications were given. Interview with the resident on 4/23/14 at 4 PM revealed s/he had taken his/her morning medicines around 10 AM because s/he didn't like to get up early. b. According to the 2013 Physician's Desk Reference Nurse's Drug Handbook carvedilol, Ditropan, and Lyrica should be given over a 24	F 333	F315 Cont. c. All nursing staff will be educated to ensure that all residents with catheters, including resident # 41 catheter bag is free from obstruction, coils in excess tubing and that the drainage bag is below the level of her bladder to prevent risk of CAUTI. Nursing Director or designee will perform ongoing monthly audits to ensure that measures are utilized for the prevention of urinary tract infections d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date F 333 The facility shall ensure that residents are free of any significant medication errors. 1. a. The physicians order for Phenobarbital for resident # 70 has been clarified. The nursing staff will be instructed to complete medication reconciliation	06/06/2014 4/10/14 cle

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 17 hour period in divided doses for the maximum effect of the drugs to control the signs and symptoms of diseases. In addition, carvedilol, "plasma concentrations are 50% higher in the elderly", and Symbicort should be administered, "12 hours apart in the AM/PM for maximum effectiveness". Also, Ditropan, "duration of action is 6-10 hours", and to control symptoms of urinary frequency/urgency doses should be timed accordingly. Interview with RN #6 on 4/24/14 at 9 AM revealed AM meds were given from around 7 AM until noon, and PM meds were given after 3 PM. Interview with RN #5 on 4/24/14 at 9:05 AM showed AM meds were supposed to be administered between 7 and 10 AM and PM meds between 4 and 6 PM. Bedtime medications were administered when the resident went to bed. Interview with RN #4 on 4/24/14 at 9:15 AM revealed AM medications were supposed to be administered between 7 and 10 AM and PM medications between 3:30 to 6:30 PM. Bedtime medications were administered at different times according to when the resident went to bed. Interview with the pharmacist on 4/24/14 at 10:25 AM revealed the pharmacist was unable to verify the times that AM and PM medications were administered. The pharmacist agreed that medication dosing should be timed based on the individual medication that was being given for the resident to receive the maximum effect of the medication.	F 333	**F333 Cont.** between the physician orders and Medication Administration Records for resident # 70 and all residents every month prior to the beginning of the new month. b. All residents have the potential to be affected by failure to ensure residents are free of any significant medication errors. c. All nursing staff will be educated regarding the need to complete medication reconciliation between the physician orders and Medication Administration Records for resident # 70 and all residents every month prior to the beginning of the new ongoing month. Nursing Director or designee will perform ongoing monthly audits to ensure that residents are free of any significant medication errors. d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 18 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure 3 of 5 microwaves were maintained in a sanitary manner and failed to ensure expired food items were not available for use in 4 of 5 kitchen areas. In addition, the facility failed to ensure the ice machine was cleaned and sanitized in accordance with manufacturer's instructions. The findings were: 1. The following concerns were identified related to maintaining equipment in a sanitary manner and ensuring expired food items were not available for use: a. Observation of the activity room kitchen on 4/23/14 at 10:01 AM revealed the inside of the microwave had dried splatters and food debris. b. On 4/23/14 at 10:05 AM observation in the South pantry showed one thawed Sysco vanilla shake was in the refrigerator. The carton was not labeled with the date the product was thawed. Review of the instructions on the carton revealed the product was good for 14 days after thawing. c. Observation on 4/23/14 at 1:35 PM in the secure care unit (SCU) kitchen revealed the inside of the microwave had dried splatters and food debris. In addition, four thawed Sysco vanilla	F 371	**F333 Cont.** responsibility to ensure the facility is in compliance. 2. Completion Date a. A line will be added to resident # 46's Medication Administration Record sheet/s for documentation of the specific time medications were administered for AM, Noon, PM, and bedtime. Powell Valley Healthcare's Nursing Procedure 2.9 titled "Charting Medication Administration" will be updated to include the statement that medications requiring specific times will be identified, and clarified with the providers as necessary, by the pharmacist to ensure efficacy of the medication. b. All residents have the potential to be affected by failure to ensure residents are free of any significant medication errors. c. Education will be provided to the nursing staff regarding requirement to document specific times of medication administration on the all resident's including resident # 46 MAR. They will also be educated regarding the updates to Nursing	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 19 shakes were in the refrigerator. The cartons were not labeled with the thaw date. Review of instructions on the cartons revealed the product was good for 14 days after thawing. d. On 4/23/14 at 4:05 PM one thawed Sysco vanilla shake was found in the refrigerator in the North pantry. The thaw date was not indicated on the carton. Review of the instructions on the carton revealed the product was good for 14 days after thawing. e. Observation of the North pantry on 4/22/14 at 9:55 AM revealed an open half loaf of white bread with an expiration date of 4/10/14. In addition there was an undated opened half loaf of wheat bread with a powdery, greenish white substance covering several slices. Interview with RN #1 at the time of the observation revealed the powdery, greenish white substance, "looks like mold." Interview further revealed she was unsure who was responsible for checking the date of foods located in the nourishment room. f. Observation of the South pantry on 4/22/14 at 10:15 AM showed an open loaf of white bread with an expiration date of 4/18/14 that was available for resident use. The inside of the microwave was covered on the bottom, sides, top and door with dried food splatter. The refrigerator contained two prepackaged containers of gelatin cubes, one green and one orange, both dated 4/10/14. Interview with the administrator at the time of the observation revealed third shift staff were responsible for checking the contents of the nutrition rooms, including checking dates and replacing stock, and cleaning the microwave. The administrator also verified the microwave was used to re-heat resident food at times. The administrator verified the date on the container of gelatin cubes was the date the food was prepared for use by dietary staff.	F 371	**F333 Cont.** Procedure 2.9. The Nursing Director or designee will perform ongoing monthly audits to ensure documentation of medication administration times d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date **F 371** The facility shall ensure that equipment is maintained in a sanitary manner and expired food items are not available for use. 1a. a. The microwave in the activity room kitchen has been cleaned and staff will be instructed to ensure regularly cleaning to ensure there are no splatters or food debris in the microwave. Cleaning of the microwaves will be added to the list of extra duties for the Recreation staff b. All residents have the potential to be affected by failure to ensure that equipment is maintained in	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 20 During an interview on 4/23/14 at 11:06 AM the dietary manager stated dietary staff was responsible for the unit pantries/kitchens when they checked them in the morning, but after that nursing staff was responsible (for cleaning and throwing away expired items). On 4/23/14 at 2:23 PM the administrator stated activities staff was responsible for the microwave in the activity room. Reference: FDA, US Public Health Service Food Code 2013. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 2. Review of the manufacturer's instructions for the facility's ice machine (Scotsman model CME506) showed "the ice machine's water system should be cleaned and sanitized a minimum of twice per year." During an interview on 4/23/14 at 3:14 PM the dietary manager stated he cleaned and sanitized the interior of the ice machine at least monthly, but did not clean and sanitize the water system in accordance with the manufacturer's instructions. He stated that maybe the maintenance department did that. However, during an interview on 4/24/14 at 8:29 AM, maintenance staff #1 stated they did not clean and sanitize the ice machine's water system either. Reference: FDA, US Public Health Service Food	F 371	**F371 Cont.** a sanitary manner and expired food items are not available for use. c. Education will be provided to the Activity staff to ensure regularly cleaning to ensure there are no splatters or food debris in the microwave. The Social Services/Activity Director or designee will perform ongoing monthly audits to ensure the microwave in the activity room kitchen is clean and sanitary. d. The Social Services/Activity Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 1b. Completion Date a. The nursing staff will be instructed to ensure the Sysco Vanilla shakes in all pantries are labeled with the date that the product was thawed and disposed of after 14 days from that date. The microwave in the secure unit, north, and south pantry has been cleaned and staff will be instructed to conduct regularly cleaning to ensure	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21 Code 2013. Cleaning of Equipment and Utensils. 4-602.11 Equipment Food-Contact Surfaces and Utensils; (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed compartments of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.	F 371	**F371 Cont.** there are no splatters or food debris in the microwave. Cleaning of all microwaves will be added to the list of extra duties for the nursing staff b. All residents have the potential to be affected by failure to ensure that equipment is maintained in a sanitary manner and expired food items are not available for use. c. Education will be provided to the nursing staff to conduct regularly cleaning to ensure there are no splatters or food debris in the microwave. Education will be provided to the all nursing staff to ensure the Sysco Vanilla shakes in all pantries are labeled with the date that the product was thawed and disposed of after 14 days from that date. The Nursing Director or designee will perform ongoing monthly audits to ensure there are no splatters or food debris in the microwave and the Sysco Vanilla shakes are labeled with the date that the product was thawed d. The Nursing Director will aggregate random monthly data and report results to the	6/10/14
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425		

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 22 by: Based on medical record review, staff interview, and review of facility policy and procedures, the facility failed to ensure a process was in place for administering AM, PM and bedtime medications at designated times. The findings were: 1. Review of the medical record showed resident #70 was readmitted to the facility on 1/24/12 with diagnoses including multiple sclerosis and seizure disorder. Review of the 3/20/14 physician's progress note showed an order for Depakote (a medication used to prevent seizures) 125 mg in the morning and 500 mg in the. Review of the April 2014 MAR revealed the patient received Depakote 125 mg in the AM and 500 mg in the PM with no specific time for AM and PM. The MAR listed AM and PM, however, there was no actual time recorded when the medication was administered. According to the 2013 Physician's Drug Reference Nurse's Drug Handbook, the drug, "should be given in divided doses to maintain serum concentrations and prevent seizures." Review of the medical record showed a nursing progress note dated 4/18/14 revealed the CNA had been performing pericare for the resident and the resident had a seizure that lasted approximately 4 minutes. 2. Observation of a medication administration pass on 4/23/14 at 3:50 PM with LPN #1 revealed resident #46 was administered carvedilol 6.25 mg (a medication that lowers heart rate and is used to treat heart failure and high blood pressure). The resident was also administered Lyrica 100 mg (used to treat neuropathy), Symbicort 160-4.5 mcg/act 2 inhalations for chronic obstructive pulmonary disease, and Ditropan 5 mg used to treat urinary urgency/frequency. The following	F 425	**F371 Cont.** Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. c. Completion Date a. The expired loaf of bread in the north and south pantry was disposed of immediately. All food items located in the nourishment room on all units will be checked for expiration dates by the night shift weekly on Monday. Expired food items will be disposed of as appropriate. b. All residents have the potential to be affected by failure to ensure that expired food items are not available for use. c. Education will be provided to the all nursing staff to ensure food items are checked for expiration dates by the night shift staff every week on Monday. Expired food items will be disposed of as appropriate. The Nursing Director or designee will perform ongoing monthly audits to ensure expired food items are not present in the nourishment room.	06/06/2014

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 23 concerns were identified: a. Review of the April 2014 MAR showed the patient received carvedilol, Ditropan and Symbicort two times daily in the AM and PM, and the Lyrica was given 4 times daily AM, Noon, PM, and bedtime. There were no specific times recorded when the medication had been administered. LPN #1 was unable to verify the time the AM medications were given. Interview with the resident on 4/23/14 at 4 PM revealed he had taken his morning medicines around 10 AM because s/he didn't like to get up early, and the bedtime medications were usually given around 7 PM. b. According to the 2013 Physician's Desk Reference Nurse's Drug Handbook carvedilol, Ditropan, and Lyrica should be given over a 24 hour period in divided doses for the maximum effect of the drugs to control the signs and symptoms of diseases. In addition, carvedilol, "plasma concentrations are 50% higher in the elderly", and Symbicort should be administered, "12 hours apart in the AM/PM for maximum effectiveness". Also, Ditropan, "duration of action is 6-10 hours", and to control symptoms of urinary frequency/urgency doses should be timed accordingly. 3. Interview with the DON on 4/24/14 at 8:50 AM verified there were no scheduled times for AM, PM or bedtime medications to be administered unless the physician ordered medications to be given at a certain time. 4. Interview with RN #6 on 4/24/14 at 9 AM revealed AM meds were given from around 7 AM until noon, and PM meds were given after 3 PM. Interview with RN #5 on 4/24/14 at 9:05 AM showed AM meds were supposed to be	F 425	**F371 Cont.** d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date **F 425** The facility shall ensure that a process is in place for administering AM, PM and bedtime medications at designated times. 1& 2. a. A line will be added to resident # 70 and resident # 46's Medication Administration Record sheet/s for documentation of the specific time medications were administered for AM, Noon, PM, and bedtime. Powell Valley Healthcare's Nursing Procedure 2.9 titled "Charting Medication Administration" will be updated to include the statement that medications requiring specific times will be identified, and clarified with the providers as necessary, by the pharmacist to ensure efficacy of the medication.	06/06/2014 6/10/14 Da

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 24 administered between 7 and 10 AM and PM meds between 4 and 6 PM. Bedtime medications were administered when the resident went to bed. Interview with RN #4 on 4/24/14 at 9:15 AM revealed AM medications were supposed to be administered between 7 and 10 AM and PM medications between 3:30 to 6:30 PM. Bedtime medications were administered at different times according to when the resident went to bed. 5. Review of facility policy and procedure, entitled, "Charting Medication Administration", reviewed/revised 4/11 showed, "Documentation pertaining to medication administration will include: 1. Date and time medication administered". Additionally the facility's policy, "Administration Of Medications", also reviewed/revised 4/11 included, medications should be administered according to, "4. Professional standards...utilizing the 6 rights of medication administration...Right Time", and, "Procedure: 4. Nurse with assign times medications will be given based on: a. Routine administration times, b. Mechanism of action". Review of an undated facility document that was included in the survey notebook provided upon entrance to the facility, entitled, "Medication Administration, medication pass times [were listed as] A.M. Med Pass 7-10 AM, Noon Med Pass Between 11 AM and 1 PM, P.M. Med Pass 4 PM and 7 PM and Bedtime Med Pass After 8 PM". 6. Interview with the pharmacist on 4/24/14 at 10:25 AM revealed medication dosing should have been divided and medications given at timed intervals as recommended for certain medications including those given to prevent seizures and manage high blood pressure.	F 425	**F425 Cont.** b. All residents have the potential to be affected by failure to ensure residents are free of any significant medication errors. c. Education will be provided to the nursing staff regarding requirement to document specific times of medication administration on the all resident's including resident # 70 and resident # 46's MAR. They will also be educated regarding the updates to Nursing Procedure 2.9. The Nursing Director or designee will perform ongoing monthly audits to ensure documentation of medication administration times. d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014 6/10/14 CA

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure drug regimen reviews were performed monthly and the physician was made aware of irregularities for 1 of 15 sample residents (#70) whose drug regimens were reviewed. The findings were: Review of the medical record showed resident #70 was readmitted to the facility on 1/24/12 with diagnoses including multiple sclerosis and seizure disorder. Observation of a medication administration pass on 4/23/14 at 3:37 PM with LPN #1 revealed the resident was administered phenobarbital (medication used to prevent seizures) 32.4 mg. The following concerns were identified: a. Review of the April 2014 MAR showed the resident was supposed to receive phenobarbital 32.5 mg. twice daily and 32.4 mg 1.5 tablets (dose =48.6 mg) at bedtime ordered on 10/28/10. Review of an electronically signed physician's progress note dated 3/20/14 with current	F 428	F 428 The facility shall ensure that a drug regimen reviews are performed monthly and physicians are made aware of irregularities. 1 a. The physicians order for Phenobarbital for resident # 70 has been clarified. The Director of Pharmacy has developed a tracking tool to verify that all monthly medication reviews are completed. The pharmacists will conduct a comparison between the medication doses ordered by the physician with the current dose listed on the MAR to ensure accurate dosing. The Pharmacists with clarify inconsistencies and report irregularities to the physician. b. All residents have the potential to be affected by failure to ensure that drug regimen reviews are completed monthly and irregularities reported to physicians. c. All Pharmacists will be educated on the use of the tracking tool to verify that all monthly medication reviews are completed. The pharmacists will also be educated regarding the need to conduct a comparison	6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 26 medications listed showed another dose, "1. phenobarbital 30 mg in the morning, 30 mg in the evening, 45 mg at bedtime". b. Review of the medical record showed a nursing progress note dated 4/18/14 revealed the CNA had been performing pericare for the resident and the resident had a seizure that lasted approximately 4 minutes. c. Review of medication reviews showed the resident's medications had been reviewed by the pharmacist on 11/21/13 and 2/4/15. The review dated 2/4/14 revealed, "Dec 2013: Patient had [his/her] first seizure in years...Meds and levels are appropriate". Interview with the pharmacist on 4/24/14 at 10:25 AM verified drug regimen reviews were supposed to be completed once a month, however, no documentation was available for December 2013 or January and March of 2014 for the resident. Interview further revealed phenobarbital was not available in 32.5 mg, however, it was available in 32.4 mg. The pharmacist was not aware of the physician's progress note that listed the phenobarbital dose as 30 mg twice a day and 45 mg at bedtime. The pharmacist verified the medication dose should have been clarified with the physician, and the MAR dose should have matched the dose that was given to the patient.	F 428	**F428 Cont.** between the medication doses ordered by the physician with the current dose listed on the MAR to ensure accurate dosing. The Pharmacist with clarify inconsistencies and report irregularities to the physician. The Pharmacy Director or designee will perform ongoing monthly audits to ensure that drug regimen reviews are performed monthly and physicians are made aware of irregularities. d. The Pharmacy Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	**F 441** The facility shall ensure that the infection control program is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	6/19/14 CA

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure and current standards of practice, and staff interview, the facility failed to ensure sterile aseptic technique was utilized during 2 of 2 observations of a urinary catheter insertion. The facility also failed to ensure staff did not perform resident care while wearing contaminated	F 441	**F441 Cont.** 1. a. RN # 1 and LPN #1 will be reeducated regarding strict sterile techniques when performing intermittent urinary catheterizations for resident # 50 per the facility procedure provided by Lippincott, Williams & Wilkins Nursing Procedures, 5th edition. b. All residents have the potential to be affected by the failure to ensure measures are utilized for the prevention of urinary tract infections c. All nursing staff will be educated regarding strict sterile techniques when performing intermittent urinary catheterizations for all residents and including resident # 50 per the facility procedure provided by Lippincott, Williams & Wilkins Nursing Procedures, 5th edition. Sterile technique for urinary catheterization will be added to the annual nursing skills The Care Center Nursing Director or designee will perform ongoing monthly audits to ensure that	6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28 clothing for 1 random observation. In addition, the facility failed to ensure glucometers were appropriately disinfected and gloves were worn while administering injectable medication during 1 of 2 observations of a medication administration pass. The findings were: 1. Related to urinary catheter insertions: During an observation of a urinary catheterization for resident #50 on 4/22/14 at 10:40 AM RN #1 opened the sterile catheter kit and prepared the sterile contents with bare hands contaminating the sterile contents of the insertion kit. RN #1 removed the top tray of the insertion kit, which contained sterile gloves, and placed it on an unsterile field. The RN used her bare hands to open sterile packages of lubricant and betadine then saturated cotton balls with betadine. The RN placed a barrier under the residents's perineal area with bare hands and noticed the resident had been incontinent of bowel. The RN applied gloves and assisted CNA #1 clean the patient of loose, brown stool. The RN removed her gloves but did not wash her hands then proceeded to apply the sterile gloves contained in the catheter insertion kit. She applied the sterile gloves touching and adjusting the fit of the gloves with bare hands. The RN cleansed the patient's urethral opening with the betadine saturated cotton balls from the opening down toward the buttocks 3 times. After the catheterization was complete, the RN continued to wear the same visibly soiled gloves and opened the privacy curtains to empty the resident's urine then re-opened the privacy curtains with the same visibly soiled gloves. b. Additional observation of a urinary catheterization for resident #50 on 4/22/14 at 4:05	F 441	**F441 Cont.** measures are utilized for the prevention of urinary tract d. The Care Center Nursing Director or designee will aggregate random monthly data and report results to the Administrator, Care Center Medical Director, and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. Completion Date a. CNA # 1 will be instructed to change clothing that becomes contaminated and that clean uniforms are available in the ER or OR. b. All residents have the potential to be affected by failure to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection by changing contaminated clothing. c. Education will be provided to the nursing staff regarding the need to change clothing that becomes contaminated and that clean uniforms are available in the ER and OR. The Nursing Director or designee will perform ongoing monthly random	06/06/2014 6/10/14 ae

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 29 PM with LPN #1 revealed she cleansed the resident's urinary meatus downward toward his/her buttocks 4 times. The LPN lubricated and inserted the catheter, however, no urine was returned and the catheter was removed. LPN #1 then removed her gloves, washed her hands and opened another sterile catheter insertion kit and catheter. The LPN removed the sterile gloves from the kit and applied them, however, sterility was compromised when bare hands touched the outside surface of the gloves to position and adjust the gloves fit. The nurse cleansed with betadine saturated cotton balls from the urinary meatus down toward the buttocks 3 times and inserted the lubricated catheter, however, no urine was returned and the catheter was removed. The LPN attempted a third time, however, no new sterile cath insertion kit was opened and the resident's urethral opening was not cleaned at all. c. Review of the resident's medical record showed the resident had a urine culture completed on 12/17/13 and was treated with oral antibiotics for UTI. The resident's urine culture was positive for 3 baterium that are commonly found in the gastrointestinal tract (escherichia coli, proteus mirabills, and klebsiella oxytoca). d. Interview with the DON on 4/23/14 at 11 AM revealed he expected staff to follow the facility's policy and procedure for inserting urinary catheters and maintain sterile technique. e. Review of the facility's procedure for urinary catheter insertion showed the facility followed, "Lippincott's Nursing Procedures, 6th edition." The following instructions for insertion were listed, "A urinary catheter is inserted using sterile technique...should be performed with extreme care and caution to prevent injury and infection...perform hand hygiene and put on	F 441	**F441 Cont.** audits to conduct regularly cleaning to ensure uniform tops are free from contamination. d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 3. Completion Date a. RN # 2 will be instructed regarding the need to allow the glucometer to remain wet with the cleansing solution for 2 minutes prior to drying and storing. b. All residents have the potential to be affected by failure to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection by changing contaminated clothing. c. Education will be provided to the nursing staff regarding the need to allow the glucometer to remain wet with the cleansing solution for 2 minutes prior to drying and storing. The Nursing Director or designee will perform	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 30 gloves. To create a sterile field open the prepackaged kit and place it between the patient's legs. If the sterile gloves are the first item on top of the tray , put them on...Take care not to contaminate your gloves...Separate the labia majora and labia minora as widely as possible with the thumb, middle and index fingers of your nondominant hand so you have a full view of the urinary meatus. Keep the labias well separated through the process..so they don't contaminate the area when it's cleaned. With your dominant hand wipe [the cotton ball saturated with betadine] one side of the the urinary meatus with a downward motion...Wipe the other side in the same way. Then wipe directly over the meatus with another sterile applicator or cotton ball. Take care not to contaminate your sterile glove...If the catheter is inadvertently inserted into the vagina, leave it there as a landmark. Then begin the procedure over again using new supplies...Dispose of all used supplies...remove you gloves and discard. Perform hand hygiene." f. According to Medical Microbiology 6th edition, 2009 most UTIs are caused by, "The coliform organisms and Proteus species are major causes of diseases acquired outside the hospital; many of these diseases eventually require hospitalization. Escherichia coli causes approximately 85 percent of cases of urethrocystitis (infection of the urethra and bladder), about 80 percent of cases of chronic bacterial prostatitis, and up to 90 percent of cases of acute pyelonephritis (inflammation of the renal pelvis and parenchyma). Approximately one half of females have had a urinary tract infection by their late twenties due to E coli from their fecal flora caused by improper wiping or contaminated urinary catheter insertion. Proteus, Klebsiella, and	F 441	**F441 Cont.** ongoing monthly random audits to ensure nursing staff is allowing glucometer's 2 minutes to remain wet be prior to drying and storing. d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 4. Completion Date a. RN # 2 will be instructed regarding the need to perform hand hygiene and put on gloves prior to administering injections to resident # 51. b. All residents have the potential to be affected by failure to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection by performing hand hygiene and putting on gloves prior to an injection. c. Education will be provided to the all nursing staff regarding the need to perform hand hygiene and putting on gloves prior to	06/06/2014 6/10/14

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 31 Enterobacter species are among the other organisms most frequently involved in urinary tract infections. Proteus, particularly P mirabilis, is believed to be the most common cause of infection-related kidney stones, one of the most serious complications of unresolved or recurrent bacteriuria. Adherence to general infection control principles is important (e.g., hand hygiene, surveillance and feedback, aseptic insertion, proper maintenance, education)." 2. Related to contaminated clothing: During an observation of a urinary catheter insertion for resident #50 on 4/22/14 at 10:40 AM CNA #1 assisted RN #1 with cleaning the resident who had been incontinent of loose brown feces. The resident was rolled to his/her left side to clean the feces and the CNA was leaned over the bed when the resident had an episode of flatus (gas) expelling loose watery feces onto the CNA's gloved hands, bare arms and uniform shirt which was partially, loosely hanging onto the mattress. The CNA washed her hands and arms with soap and water and re-applied gloves, however, at 5:15 PM she was observed assisting other resident's with ADLs, including the evening meal, wearing the same uniform shirt. Interview with the DON on 4/24/14 at 8:50 AM revealed uniform scrubs were available to staff if their clothing became contaminated and the facility laundered the staffs soiled clothing. The DON also verified he expected staff with soiled clothing to change and have their clothing laundered by the facility. 3. Related to glucometer disinfection:	F 441	**F441 Cont.** administering injections to resident# 51 and all residents. The Nursing Director or designee will perform ongoing monthly random audits to ensure nursing staff is performing hand hygiene and putting on gloves prior to administering injections. d. The Nursing Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014 6/10/14 DC

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 32 Observation of a medication pass with RN #2 on 4/23/14 at 11:20 AM showed the RN performed a fingerstick blood sugar test on a resident. The RN then used a Super Sani-wipe to clean the glucometer; however the glucometer was not allowed to remain wet for 2 minutes prior to drying and storing. Interview with the RN at the time of the observation revealed she was unaware the glucometer had to remain wet for 2 minutes prior to drying and storing. Review of an undated facility policy for cleaning glucometers showed, "8. Clean the instrument between each use. b. Gently wipe the meter's surface using a Super Sani-cloth germicidal disposable cloth...g. Allow surface of meter to remain damp with germicidal solution for 2 minutes before drying completely." 4. Related to insulin administration: During an observation of a medication administration pass for resident #51 on 4/23/14 at 11:47 AM RN #2 administered subcutaneous insulin into the resident's abdomen with bare hands. Interview with the RN at the time of the observation revealed she had never worn gloves when administering subcutaneous insulin. Review of the facility's procedure for "subcutaneous injection" showed the facility followed, "Lippincott, Williams, & Wilkins Nursing Procedures, 5th edition." The following instructions were listed, "Perform hand hygiene and put on gloves...[administer injection] Remove and discard your gloves and perform hand hygiene." According to, "The Long Term Care Guide for	F 441		6/10/14 dc

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 33 Infection Control" copyright 2008, "Gloves serve an important purpose in infection control...and are worn to provide a barrier against pathogens and prevent contamination...gloves should be worn in all situations where you may come in contact with blood or body fluids (administering injectable medications)...gloves should be changed when contaminated and between soiled and clean areas". In addition, current standards of practice from the Centers for Disease Control (CDC) dated May 2011, "Standard Precautions are the minimum prevention practices that apply to all patient care...2. use of personal protective equipment [gloves] should be worn when there is contact with blood and/or body fluids."	F 441		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were securely fastened and maintained on 3 of 4 hallways used by residents. The findings were: Tour of the facility on 4/23/14 beginning at 10 AM revealed 14 places on the handrails in the main hallway leading to the dining room that were loose from the wall or had gaps in materials that presented abrupt edges. Further observations found similar conditions in both North (7 gaps with abrupt edges) and South (5 gaps with exposed edges) hallways.	F 468	**F 468** The facility shall ensure that handrails are securely fastened. 1. a. The handrails in the main hallway leading to the dining room, North and South hallways will be securely fastened to prevent gaps and areas that are loose from the wall. Staff will be instructed to complete maintenance work orders for repair of any loose handrails. b. All residents, staff and visitors have the potential to be affected by failure to ensure that handrails are securely fastened 6/10/14	

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 _____	04/24/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 34 The maintenance director stated in an interview on 4/24/14 at 10:05 AM that many of the handrails were new and needed to be adjusted after resident use. He confirmed the loose rails and gaps in the areas identified and acknowledged the potential for skin tears or abrasions if residents hit abrupt or exposed edges.	F 468	**F468 Cont.** c. Education will be provided to staff regarding the need to complete maintenance work orders for repair of any loose handrails. The Plant Operations Director or designee will perform ongoing monthly random audits to ensure that handrails are securely fastened. d. The Plant Operations Director will aggregate random monthly data and report results to the Administrator, Care Center Medical Director and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	06/06/2014

6/10/14
QA