Approved a change on page 1 after discussion & VHA on 7/25/14 at 10:32 AM Linda Brown RN

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

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FORM APPROVED
WY Dept of Health
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	R 07/02/2014

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 000}	INITIAL COMMENTS	{F 000}	F 282 The facility shall ensure staff provides care in accordance with the written plan of care.	
{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, staff interview, and review of the facility's plan of correction the facility failed to ensure staff provided care in accordance with the written plan of care for 1 of 4 sample residents (#47). The findings were: Review of the medical record for resident #47 showed a current care plan updated by staff on 5/13/14 which identified the resident as having an actual stage II pressure ulcer located on the right gluteal fold (crease of the right buttock). Nursing interventions included monitoring and documenting the depth, width, skin color, blood supply, and condition of the skin surrounding the wound once a week. The following concerns were identified: a. Observation on 7/1/14 at 10:10 AM revealed the resident continued to have a stage II pressure ulcer on the right gluteal fold which presented as a shallow crater and measured approximately 1cm (centimeter) by 0.5cm. b. Review of a nursing note and wound documentation dated 5/13/14 showed the resident's skin assessment had revealed a stage	{F 282}	1. a. The completion of a skin assessment has been scheduled weekly on the Treatment Administration Record (TAR) for resident # 47 and all residents with a skin care guide. All nursing staff has been educated that required weekly assessments for existing skin care guides have been placed on the TAR and must be completed on Mondays by the day shift. The nursing staff has also been instructed to add this intervention to the TAR any time a new skin care guide is initiated. Staff was instructed that the weekly assessment of the wound must include a description of the skin problem with the location, size, wound bed appearance, exudate and any pain. b. All residents have the potential to be affected by not providing care in accordance with the resident's individualized plan of care. all current resident care plans will be included in the weekly audits c. All nursing staff has been educated to follow the plan	

added & permission of VHA on 7/25/14 at 10:32 AM Linda Brown RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nicole DStarmiller RN
TITLE: Administrator
(X6) DATE: 7/23/14

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.

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 _____	R 07/02/2014

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 1 II pressure ulcer located on the right gluteal fold which measured 3.2cm by 0.6cm and was 0.2cm deep. Additional review of nursing notes and wound documentation showed no further documentation of the resident's wound until 7/1/14 (49 days later). c) Interview with the administrator on 7/1/14 at 1:30 PM verified no further documentation of the resident's wound was available. The interview further revealed she expected staff to follow the care plan. d) Review of the facility's plan of correction dated 6/6/14 showed, "all nursing staff will be educated on the importance of following the residents plan of care and to complete an assessment of the wound weekly and PRN [as needed] progress notes to include a description of the location, size, wound bed appearance, and exudate [drainage]."	{F 282}	of care to complete a weekly progress note for residents with a skin care guide. Staff has also been educated that required weekly assessments for existing skin care guides have been placed on the TAR and must be completed on Mondays by the day shift. The nursing staff has also been instructed to add this intervention to the TAR any time a new skin care guide is initiated. Staff was instructed that the weekly assessment of the wound must include a description of the skin problem with the location, size, wound bed appearance, exudate and any pain. The Care Center Nursing Director or designee will conduct weekly audits to ensure care is provided 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	07/30/2014

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535045	A. Building B. Wing	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0167 Reg. # 483.10(g)(1) LSC	Correction Completed 06/06/2014	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/06/2014	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 06/06/2014
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 06/06/2014	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 06/06/2014	ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 06/06/2014
ID Prefix F0333 Reg. # 483.25(m)(2) LSC	Correction Completed 06/06/2014	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 06/06/2014	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 06/06/2014
ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 06/06/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/06/2014	ID Prefix F0468 Reg. # 483.70(h)(3) LSC	Correction Completed 06/06/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TS 7/31/14	Date:	Signature of Surveyor: Linda Brown / TS	Date: 7-31-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/24/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO