POC accepted 3/11/11 Janelle Cook, OM

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

PRINTED: 02/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	01/27/2011

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

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide LPN- Licensed Practical Nurse MDS- Minimum Data Set RD- Registered Dietitian ROM- Range of Motion Less commonly used abbreviations will be annotated in each deficiency.	F 000	F282 The facility will ensure that care if provided in accordance with the written plan of care. A. All staff will be instructed to follow the ROM care plan for resident #14, #29, and #54. All staff will be instructed to follow the toileting care plan for resident #29. B. All residents have the potential to be affected by staff not following the plan of care. C. Education will be provided to all nursing, recreation, and restorative staff on the importance of following the restorative care plan for each resident. The MDS Director or designee will perform random audits monthly to ensure that all residents have received restorative care as indicated in the residents plan of care. D. The Nursing Director will aggregate the data and report the results to the VP of Resident Care Services and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/11/2011
F 202 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 and resident interviews, the facility failed to ensure care was provided in accordance with the written plan of care for 3 of 15 sample residents (#14, #29, #54). The findings were: 1. Refer to F318 for details regarding the facility's failure to provide restorative services for ROM in accordance with the care plan for residents #14, #29, and #54. 2. Review of the care plan dated 11/2/10 for resident #29 revealed staff was instructed not to leave the resident unattended on the toilet. Observation on 1/25/11 at 9:40 AM revealed CNA #1 and nurse aide (NA) #1 transferred the	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheri Berander MSN RN — TITLE: Administrator — (X6) DATE: 2/15/2011

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.

POC accepted. Call to Cheri Berander, Administrator on 3/11/11 @ 2pm. JF

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Wyoming Dept of Health
FEB 15 2011
Office of Healthcare Licensing and Surveys

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F 282	Continued From page 1 resident to the toilet using a sit-to-stand lift. The CNA and NA then left the bathroom, closing the door behind them. During an interview on 1/26/11 at 2 PM, CNA #1 stated she was not sure why the care plan instructed staff to not leave the resident unattended. LPN #1 overheard the conversation, and stated she thought the care plan was outdated. However, an interview on 1/27/11 at 9 AM with the bowel and bladder nurse revealed she was responsible for the care plan, and the care plan was current. She stated she did not want staff to leave the resident unattended while on the toilet.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to provide services to increase ROM for 3 of 6 sample residents (#14, #29, and #54) who had limited ROM. The findings were: 1. Review of the 11/1/10 quarterly MDS assessment showed resident #29 had ROM limitations to both upper extremities and both lower extremities. Observation on 1/25/11 at 9:40 AM revealed the resident was transferred using a	F 318	F 318 The facility will ensure that services are provided to increase residents ROM. A. All restorative CNA's will follow the treatment plan for residents #14, #29 and #54.. B. All residents with a restorative treatment plan have the potential to be affected. C. Education will be provided to Restorative CNA's to include the importance of following residents restorative treatment plans. The Restorative Director will perform monthly audits to ensure that restorative treatment plans are being followed. D. The Restorative Director will aggregate the data and report the results monthly to the VP of Resident Care Services and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/11/2011

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F 318	Continued From page 2 sit-to-stand lift and had limited active ROM to the upper extremities. Review of the restorative care plan dated 11/3/10 showed staff was supposed to provide assisted ROM services three times per week. However, review of the restorative participation documentation revealed ROM services were only provided three times in December 2010. In January 2011, services were only provided once the first week and twice during the second and third weeks. 2. Medical record review for resident #14 revealed a quarterly MDS assessment completed on 10/26/10 which revealed the resident had limited ROM in one upper extremity. Further record reviewed showed a care plan dated 11/4/10 which indicated the resident was to have active range of motion (AROM) and passive range of motion (PROM) 2-3 times a day. The following concerns were noted: a. Interview on 1/26/11 at 10 AM with resident #14 revealed the staff did not do any ROM exercises with the resident. b. Review of the resident's restorative participation record revealed services were provided from 0-5 times a week in December 2010 and January 2011, but further review showed restorative only assisted in ambulating the resident and no ROM was provided. c. Interview on 1/26/11 at 2:15 PM with the restorative nurse coordinator revealed restorative services should have provided ROM exercises with the resident as stated in the care plan. 3. Review of the 11/23/10 quarterly MDS assessment showed resident #54 had ROM limitations to both legs and feet. According to the 12/1/10 care plan, the resident was to receive restorative active/active assist ROM to all	F 318		

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F 318	Continued From page 3 extremities three times per week. Review of the participation flowsheets revealed the following concerns: a. In December 2010, the resident refused participation in ROM exercises on 12/22/10, and no other documentation was noted. b. In January 2011, the resident participated in ROM exercises on 1/3/11, 1/5/11, 1/10/11, and 1/21/11. Further documentation showed the resident refused participation in ROM exercises on 1/17/11, and no other documentation was noted. c. During an interview on 1/27/11 at 8:25 AM, the resident stated s/he was offered ROM exercise once a week by staff. 4. During an interview on 1/26/11 at 4:50 PM, the restorative nurse coordinator stated sometimes restorative services did not get done because of issues with staffing. She also stated staff might not always document services provided. She added it "was a little of both."	F 318		
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325	F 325 The facility will ensure that interventions are developed to maintain body weight for those residents who have weight loss. . A. The following interventions will be put in place for resident #29; thickened supplements three times per day, portion sizes changed to large, weekly weight and evaluation by nursing to the presence of edema and the use of diuretics secondary to a medical diagnosis of CHF.	

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F 325	Continued From page 4 by: Based on observation, medical record review and staff interview, the facility failed to develop interventions to maintain body weight for 1 of 2 sample residents (#29) with weight loss. The findings were: 1. Review of the 11/1/10 quarterly MDS assessment showed resident #29 was 68 inches tall and weighed 187 pounds (lbs). The assessment indicated the resident had experienced a weight loss of 5% in the last month or 10% in the last 6 months, and was not on a physician-prescribed weight-loss regimen. Review of the weight history showed the resident's most recent weight was 179 lbs on 1/26/11, compared to 183.3 lbs on 12/15/10 (loss of 4.3 lbs), 190 lbs on 10/13/10 (loss of 11 lbs), and 203 lbs on 7/14/10 (loss of 26 lbs). Observation on 1/25/11 at 8:15 AM revealed the resident required total staff assistance for eating, received a pureed diet and thickened liquids, and consumed 90% of the meal. The following concerns were identified: a. Review of an RD note dated 7/30/10 showed the resident ate 97% of meals, had lost some weight, and no new interventions were planned. A nutrition assessment dated 11/1/10 revealed the resident had a weight loss of 10.35% in the last 180 days. The RD wrote "...wt. is down 10% over 180 days. Will continue to monitor." There lacked evidence any nutritional interventions were implemented once the weight loss was identified. b. During an interview on 1/26/11 at 3:40 PM, the RD stated the resident's intake was great, and she couldn't pinpoint why the resident was losing weight. When asked what interventions were in place, the RD stated she made nursing staff	F 325	B. All residents have the potential to be affected by the failure to identify interventions to aid in the prevention of weight loss. C. Resident weights will be monitored weekly. A Significant Weight Loss Procedure will be put into place for those who trigger a 5 % or more weight loss. A tracking tool will be developed to ensure interventions have been put into place according to the policy. D. The Dietitian will aggregate the data and report the results monthly to the VP of Resident Care Services and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	03/11/2011

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F 325	Continued From page 5 aware that the resident needed to consume 100% of meals. The RD stated the resident was not receiving supplements, and she couldn't remember why they had not tried supplements with him/her. When asked about meal fortification, the RD replied "we don't do fortification here."	F 325	F 431 The facility will ensure medications are labeled with a visible expiration date. A. All nursing staff will be instructed to ensure that name labels on the eye drops of residents #7, #13, #15, #17, #55, #64, #68 have been removed and reapplied in a way that allows for the visualization of the expiration date. B. All residents have the potential to be affected by the use of expired drugs. C. All nursing staff will educated to check labels on medications to ensure that name labels are not covering manufacture expiration dates and the importance of such. A Nursing Director will perform random monthly audits to ensure expiration dates are visible. D. The Dietitian will aggregate the data and report the results monthly to the VP of Resident Care Services and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 03/11/2011	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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F 431	Continued From page 6 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications were labeled with expiration dates in 2 of 3 medication carts. The findings were: Observation on 1/26/11 at 3:25 PM of the long hall medication cart revealed residents #7, #13, #15, and #17 each had a bottle of artificial tears eye drops labeled with their names. The labels with the residents' names covered the expiration dates on the bottles. RN #1 confirmed the expiration dates were not visible. Further observation at that time of the north short hall medication cart showed bottles of artificial tears for residents #55 and #64 which had expiration dates covered by name labels. In addition a bottle of Systane eye drops for resident #68 had no visible expiration date and the label on a bottle of Akwa tears was illegible. Interview with LPN #2 confirmed expiration dates were not visible on identified eye drop bottles.	F 431		
F 468 SS=D	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 attach a four foot section of	F 468		

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F 468	Continued From page 7 handrail to the wall in one of five wings. The findings were: Observation on 1/26/11 at 11:48 AM revealed a four foot span of wall in the secure care unit (SCU) without a handrail. The span was between resident rooms 209 and 210. The doors to each resident room were four feet in width. Combining the two door widths with the empty wall space, the total distance of missing ambulatory support was approximately 12 feet. Interview with the maintenance manager at the time of the observation confirmed the lack of a handrail. The manager stated he had never noticed the empty wall. Interview with housekeeper #1 at the same time revealed that she occasionally noticed resident #43 would habitually walk the hallway using the handrails for support and direction but, when s/he approached the empty wall space, the resident was hesitant to continue walking.	F 468	**F468** The facility will equip corridors with firmly secure handrails. A. The engineering technician will install a section of handrail between room 209 and 210. B. All residents have the potential to be affected by failing to provide handrails. C. The Director of Plan Operations or designee will perform routine inspections to assure handrails are installed and properly maintained. D. The Director of Plan Operations will aggregate the inspection data and report the information to the Safety Committee on a monthly basis. The Safety Committee will have the overall responsibility to ensure the facility is in compliance. Completion Date 02/11/2011	
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure laboratory tests were performed as ordered by the physician for 1 of 15 sample residents (#76). The findings were:	F 502		

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F 502	Continued From page 8 Review of the 11/02/09 physician admission orders for resident #75 revealed he/she was admitted with several diagnoses including hyperlipidemia and low HDL (high density lipoprotein). The admission order also prescribed Crestor 10 milligrams (mg) at bedtime. In addition, the admission order included liver enzyme studies (ALT) to be conducted at the time of admission and every six months thereafter. Further review of the medical record revealed every monthly recap of physician orders repeated the same information. Review of the resident's lab studies revealed the last ALT level was conducted on 5/3/10. Interview with RN #2 on 1/25/11 at 10:20 AM revealed she was unsure why the order was missed.	F 502	**F 502** The facility will ensure that laboratory tests are preformed as ordered by the physician. A. The physician of resident #75 will be contacted to obtain an order to perform the ALT, which was inadvertently omitted. B. All residents have the potential to be affected by the failure to provide laboratory services as ordered by the physician. C. Education will be provided to nursing staff and ward clerks of the importance of following physicians' laboratory orders. The nursing director or designee will perform monthly random audits on those individuals receiving laboratory services to ensure they are provided as ordered by the physician. D. The Nursing Director will aggregate the data and report the results monthly to the VP of Resident Care Services and the Care Center Medical Director and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 03/11/2011	