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

PRINTED: 06/05/2015
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
	535046	A. BUILDING ______ B. WING ______	05/21/2015

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 The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Pratical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 225 F 225 The facility shall not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authority.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	A. Documentation for CNA #1 will be provided to show the State nurse aide registry was checked to verify this CNA was listed and without abuse findings for all states of CNA licensure. This was completed on 5/20/2015. A. Documentation for CNA #2 will be provided to show the State nurse aide registry was checked to verify this CNA was listed and without abuse findings for all states of CNA licensure. This was completed on 5/20/2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Care Center Nursing Director — TITLE — (X6) DATE 6-30-15

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.

Changes made per phone call with Jason Delney, DON

JUN 24 2015 7/2/15 @ 5pm. POC accepted.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on employee file review, and staff interview, the facility failed to ensure the nurse aide registry was checked prior to employment for 3 of 4 CNAs (#1, #2, #3). The findings were: Review of the employee files for CNAs #1, #2, and #3 revealed there was no documentation to show the state nurse aide registry was checked to verify these CNAs were listed and without abuse findings. Interview with the human resource (HR) director and the DON on 5/19/15 at 4:40 PM verified these CNAs were hired through travel agencies and were certified in other states. The HR director verified in this state, the CNAs had temporary licenses and the state nurse aide registries from the states where they were certified had not been checked prior to employment. The CNAs were hired on: a. CNA #1 was hired on 5/4/15 b. CNA #2 was hired on 4/28/15	F 225	A. Documentation for CNA #3 will be provided to show the State nurse aide registry was checked to verify this CNA was listed and without abuse findings for all states of CNA licensure. This was completed on 5/20/2015 B. All residents have the potential to be affected by the facility employing individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. C. Education will be provided to the Human Resources Director that all CNAs hired through travel agencies must have documentation listing the individual on the State nurse aide registry for all states of licensure prior to employment. The Human Resources Director will complete monthly audits to ensure that all CNAs hired through travel agencies have documentation listing the individual on the State nurse aide registry for all states of licensure prior to employment. D. The Human Resources Director will aggregate monthly data and	

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F 225	Continued From page 2 c. CNA #3 was hired on 5/19/15	F 225	F 225 Cont. will report results to the Administrator, 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 6/30/15	
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, medical record review, and policy and procedure review, the facility failed to promote dignity for 3 of 13 sample residents (#36, #41, #77). The findings were: 1. Review of the 4/21/15 quarterly MDS assessment showed resident #77 had diagnosis that included diabetes mellitus and required finger stick blood sugars with insulin administration. Further, the assessment showed the resident was severely cognitively impaired. Observation on 5/18/15 at 3:40 PM showed RN #1 approached the resident at the nurses' station and cleaned the resident's left ring finger. The nurse prepared the glucometer strip and obtained a blood sample. The nurse told the resident what the glucometer reading was and returned to the medication cart to obtain 30 units of 70/30 humulin insulin. The nurse re-approached the resident at the nurses' station and lifted the resident's shirt exposing part of the resident's abdomen and administered the insulin. The resident was not offered privacy for the finger stick blood sugar or the insulin administration. Seven staff members and five residents were	F 241	F 241 Cont. The facility shall 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. A. Resident #77 will be treated with respect and dignity and will be offered privacy for finger stick blood sugars and with insulin administration. A. The urine drainage bag for resident #41 was placed in a cover to maintain dignity. A. The urine drainage bag for resident #36 was placed in a cover to maintain dignity.	

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F 241	Continued From page 3 present in the area at the time of the observation. Interview with the administrator on 5/21/15 at 10:50 AM revealed the resident should have been provided privacy while obtaining blood glucose and administering insulin. Review of the policy and procedure for "Subcutaneous Injection" on page 305 showed the nurse is to "Explain the procedure to the patient, and provide privacy..." 2. The following concerns were identified related to urine collection bags and resident dignity: a. Observation of resident #41 on 5/18/15 at 2:20 PM showed the resident was laying in bed with an uncovered urine collection bag hanging on the side of the bed. The urine collection bag was able to be seen from the hallway, and urine was visible in the bag. Observation on 5/19/15 at 9:08 AM showed the resident was laying in bed with the urine collection bag hanging on the side of the bed, visible from the hallway. Observation on 5/20/15 at 11:30 AM showed the resident was laying in bed with the catheter bag hanging on the side of the bed, able to be seen from the hallway and urine was visible in the bag. b. Observation of resident #36 on 5/18/15 at 2:55 PM showed the resident was sitting in a recliner with an uncovered urine collection bag hanging on the trash can. The urine collection bag was able to be seen from the hallway and urine was visible in the bag. c. Interview with the administrator on 5/21/15 at 10:40 AM revealed the facility provided covers for the catheter bags and staff was expected to cover the bags to provide dignity to the residents.	F 241	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 providing for privacy and by covering urine drainage bags. The Nursing Director or designee will complete ongoing monthly observations to ensure that privacy is provided and that drainage bags are covered to provide dignity. D. The Nursing Director or designee will aggregate monthly data and will report results to the Administrator, 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 6/30/15	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253	F 253 The facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A. The South lobby/sitting area carpet will be professionally cleaned.	

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F 253	Continued From page 4 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 5 random resident areas of the facility were clean and maintained. The findings were: 1. Observation of the south lobby/sitting area on 5/18/15 at 2 PM showed there was food and a thick liquid spilled on the carpet by the south nurses' station where residents had dined during the noon meal. Observation on 5/20/15 at 9:40 AM showed there were large areas of discoloration noted on the carpet. Observation on 5/21/15 showed the food and liquid previously observed was still present. 2. Observation of the north lobby/sitting area on 5/20/15 at 9:50 AM showed there were large areas of discoloration near the nurses' station where residents dined during meals. 3. Observation of the north shower room on 5/20/15 at 9:50 AM showed there were 52, 2 inch by 2 inch tiles that were broken, cracked, or chipped creating an uncleanable surface. 4. Observation of the south shower room on 5/20/15 at 10 AM showed there were 46, 2 inch by 2 inch tiles that were broken, cracked, or chipped creating an uncleanable surface. 5. Observation of the heater cover outside of the main dining room on 5/20/15 at 10:10 AM showed areas of discoloration and scratches, exposing	F 253	A. The North lobby/sitting area carpet will be professionally cleaned. A. The tile flooring in the North shower room will be repaired. A. The tile flooring in the South shower room will be repaired. A. The heater cover outside the dining room will be repaired and painted. B. All residents have the potential to be affected by the failure to ensure that housekeeping and maintenance services are provided to maintain sanitary, orderly, and comfortable interior. C. Education will be provided to Nursing, Maintenance, and Housekeeping staff regarding the importance of maintaining the resident's environment including stains and discoloration on the carpet, reporting cracks in flooring, and damage to heater covers. Ongoing maintenance will be performed to ensure a sanitary, orderly and comfortable environment. The Plant Operations Manager or designee will conduct weekly rounds throughout the Care Center to observe for areas in need of repair.	

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F 253	Continued From page 5 metal, that spanned the entire length of the cover. 6. Interview with custodian #1 on 5/21/15 at 8:46 AM revealed the carpets were to be cleaned once per month and had last been cleaned at the beginning of April 2015. 7. Interview with the housekeeping supervisor on 5/21/15 at 8:50 AM revealed the stains in the carpet did not "come up" when cleaned. 8. Interview with the maintenance director on 5/21/15 at 9 AM revealed there was a plan to fix the carpet and the tiles; however, no timeline for correction had been made. Further interview at that time confirmed the vent covers were dirty and needed repair.	F 253	D. The Plant Operations Manager will aggregate monthly data and report the results to the Administrator and Care Center Medical Director monthly and to the Quality Council Quarterly. The Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 6/30/2015	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279	F 279 The facility will ensure that comprehensive care plans are updated to include nutritional and speech therapy recommendations. Care plan for RD + S will be updated. A. All nurses will be instructed to ensure that all care plans are updated with physician's orders. B. All residents have the potential to be affected by not ensuring that the care plans are updated with physician's orders. C. All nursing staff will be educated on the importance of updating the resident's care plan with physician's orders. The Nursing Director or designee will perform ongoing monthly audits to ensure that all physician's orders are updated in the care plan.	

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F 279	Continued From page 6 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was updated to include nutritional recommendations for 1 of 1 sample residents (#8) with speech therapy recommendations. The findings were: Review of the 2/24/15 quarterly MDS assessment showed resident #8 had diagnoses that included dementia, and required supervision and set-up help for eating. Review of the 8/22/14 speech therapy consultation report showed the resident had a swallow evaluation completed and the recommendation was "alternating sour bolus liquid, lemon water with bites of food to improve sensory. Patient can remain on thin liquids but should be put on a mechanical soft diet with assistance at meals (cues to swallow and eat)." Review of the May 2015 physician recapitulation of orders showed the resident had orders for the sour bolus and the mechanical soft diet. The following concerns were identified: a. Review of the nutrition care plan with a target date of 2/28/15 showed the sour bolus with alternating bites of food was not mentioned. Additionally, the modified texture was not shown on the care plan. b. Observation on 6/18/15 at 12:20 PM and on 6/20/15 at 12 PM showed the resident was not provided or attempted to be provided the sour bolus. Additionally, the resident was served a regular texture meal rather than the mechanical soft texture diet at the 5/20/15 noon meal.	F 279	D. The Nursing Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	

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F 279	Continued From page 7 c. Interview with the interim dietary director on 6/20/15 at 12:10 PM verified the resident should have been served the mechanical ground hamburger that was prepared to meet the requirements of that diet order. d. Interview with the MDS nurse on 5/21/15 at 8:40 AM verified the care plan needed to reflect the current recommendations for dining and nutrition.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure professional standards were followed during 1 of 2 medication pass observations related to clarification for medication orders. The findings were: Observation of medication administration for resident #74 on 5/18/15 at 3:16 PM showed the resident was administered Labetalol (a medication to treat high blood pressure) 200 mg 1 tablet by mouth. Review of the medical record revealed the medication was ordered by a physician to be given BID (two times per day). Further review showed the medication had been changed in August 2014 from administration times of AM and PM to noon and PM. The following concerns were identified with the administration: a. Interview with the facility Pharmacist on	F 281	F 281 The facility will ensure that professional standards are followed during medication pass. A. All nursing staff will be instructed to clarify medication orders and administer medications in the appropriate time frame for resident #74. Resident #74's medication administration record was changed to ensure professional standards on 5/20/15. B. All residents have the potential to be affected by not following professional standards during medication pass. C. All nursing staff will be educated on the importance of following professional standards during medication administration. The Nursing Director or designee will perform ongoing monthly audits to ensure that professional	

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F 281	Continued From page 8 5/20/15 at 12:20 PM revealed the intent of BID medication administration is greater than 3 hours. Further interview revealed that the medication being administered at noon and again at 3:10 PM had a potential risk of low heart rate and both doses could peak at or near the same time. b. Interview with LPN #1 on 5/20/15 at 12:15 PM revealed the resident had his/her blood pressure (BP) checked one time per month unless there was an incident requiring more frequent monitoring. c. Medical record review showed the last BP taken for the resident was on 5/18/15 and was shown to be 138/80. Review of the facility's vitals summary report showed the resident's BPs were outside of normal parameters 16 out 28 times that were recorded since August 2014. These BPs ranged from 102/46 to 138/80 and a time of day was not recorded to show when the BPs were obtained. According to Smith, Duell, Martin "Clinical Nursing Skills Seventh Edition" on page 267 "a normal blood pressure in an adult varies between 100 mm Hg (millimeters of mercury) and 120 mm Hg systolic and 60 mm Hg and 80 mm Hg diastolic..." d. Interview with the administrator on 5/20/15 at 5:20 PM revealed BP monitoring was done per physician order. Further interview confirmed there was no way for the facility to ensure the blood pressure was safe without monitoring, the doses were administered too close together, and when the facility changed the time of the first dose to accommodate the resident they should have changed the time of the second dose as well.	F 281	standards are followed during medication pass. D. The Nursing Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	F 323 The facility will ensure that resident environment is free from accident hazards in the hallway near the main dining area. In addition, equipment will be evaluated for safety for residents who utilized bed devices. 1. A. The heater vent covers outside the dining room will be repaired. B. All residents have the potential to be affected by failure to repair the	

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F 323	Continued From page 9 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to ensure the resident environment remained free of accident hazards in 1 of 6 hallways (the hallway near the main dining area). In addition, the facility failed to ensure equipment was evaluated for safety for 4 of 8 residents (#8, #36, #41, #77) who utilized bed devices. The findings were: 1. Observation on 5/20/15 at 10:10 AM showed 3 heater vent covers outside the main dining room were loose from the unit and had exposed ¾ inch sharp metal edges pointing outward. Interview with the maintenance director on 5/21/15 at 9 AM confirmed the edges caused a potential for injury to residents. 2. Review of the 3/10/15 quarterly MDS assessment showed resident #41 was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 9/15, and had diagnoses that included seizure disorder. Observation on 5/19/15 at 9:05 AM showed a half side rail was attached to both upper sides of the bed. The device was designed to have gaps between the bars. Observation and measurement at that time showed there were 4 gaps between the bars that measured 3 1/2 inches by 10 inches and 2 smaller gaps at the top. Review of the	F 323	heater vent covers outside of the dining room. C. Staff will be educated to submit maintenance work orders for repair of any damaged heater vent covers. The Plant Operations Manager or designee will perform ongoing monthly visual inspections to ensure there are no damaged heater vent covers. D. The Plant Operations Manager will aggregate monthly data and will report results to the Administrator, Care Center Medical Director, and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. A. Equipment will be evaluated for safety for resident #41 who utilized bed devices. Individualized safety assessment will address the risk for potential limb entrapment. A. Equipment will be evaluated for safety for resident #8 who utilized bed devices. Individualized safety assessment will address the use of 2 half side rails and bolster mattress.	

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	535045	A. BUILDING _____ B. WING _____	05/21/2015

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 323	Continued From page 10 resident's medical record revealed that a safety assessment was completed, however the assessment was not individualized and it failed to address the safety risk related to the resident's seizure disorder and potential for limb entrapment. 3. Review of the ADL care plan with a target date of 6/26/15 showed resident #8 had dementia and required assistance with bed mobility and used a bed rail for support (2 half side rails). Review of the 2/16/15 side rail risk assessment showed the side rails were "indicated", however failed to include any individualized assessment of possible safety concerns related to this resident's physical function or mental confusion when using the side rails. In addition, observation on 5/20/15 at 10:45 AM showed the resident's bed only had one half side rail at that time, and the bed was fitted with a bolster mattress (a mattress with raised edges). Review of the medical record failed to show any assessment for the use of the bolster mattress. Interview with the DON on 5/21/15 at 12 PM verified the bolster mattress had been in use since approximately January 2015 and he was unable to find documentation to show it was assessed for safety. 4. Review of the 4/21/15 quarterly MDS assessment showed resident #77 was severely cognitively impaired with a BIMS score of 6/15, and had diagnoses that included non-Alzheimer's dementia. Observation on 5/19/15 at 9:10 AM showed a half side rail was attached to both upper sides of the bed. The device was designed to have gaps between the bars. Observation and measurement at that time showed there were 2 gaps between the bars that measured 4 1/2 inches by 26 inches. Review of the resident's	F 323	A. Equipment will be evaluated for safety for resident #77 who utilized bed devices. Individualized safety assessment will address the risk for potential limb entrapment. A. Equipment will be evaluated for safety for resident #36 who utilized bed devices. Individualized safety assessment will address the risk for potential limb entrapment. B. All residents have the potential for injury by failure to assess utilized bed devices. C. Education will be provided to nursing staff regarding the importance of assessing the safety of residents who utilized bed devices. The Nursing Director or designee will perform ongoing monthly audits to ensure that individualized safety assessments are completed on residents utilizing bed devices.	

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F 323	Continued From page 11 medical record revealed that a safety assessment was completed; however, the assessment was not individualized and it failed to address the resident's dementia and potential for limb entrapment. 5. Review of the 3/24/15 quarterly MDS assessment showed resident #36 was cognitively intact with a brief interview for mental status (BIMS) score of 15/15, and diagnoses that included other fracture. Observation on 5/18/15 at 2:55 PM showed a half side rail was attached to outer upper side of the bed with the other side against the wall. The device was designed to have gaps between the bars. Observation and measurement at that time showed there were 2 gaps between the bars that measured 4 1/2 inches by 26 inches. Review of the resident's medical record revealed that a safety assessment was completed, however the assessment was not individualized and it failed to address the potential for limb entrapment. 6. Interview with the administrator on 5/21/15 at 10:48 AM confirmed the side rail assessments were not individualized and failed to address safety related to possible limb entrapment.	F 323	D. The Nursing Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to ensure	F 333	F 333 The facility will ensure that residents are free of any significant medication errors. A. All nursing staff will be instructed to clarify medication orders and administer medications in the appropriate time frame for resident #74. Resident #74's medication administration record was changed to correct medication administration time on 5/20/15. B. All residents have the potential to be affected by failure to ensure residents are free of any significant medication errors.	

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F 333	Continued From page 12 there were no significant medication errors during 1 of 2 medication pass observations. The findings were: Observation of medication administration for resident #74 on 5/18/15 at 3:18 PM showed the resident was administered Labetalol (a medication use to treat high blood pressure) 200 mg 1 tablet by mouth. Review of the medical record revealed the medication was ordered by a physician to be given BID (two times per day). Further review showed the medication had been changed in August 2014 from administration times of AM and PM to noon and PM. The following concerns were identified with the administration: a. Interview with the facility Pharmacist on 5/20/15 at 12:20 PM revealed the intent of BID medication administration is greater than 3 hours between doses. Further he revealed the medication being administered at noon and again at 3:18 PM had a potential risk of low heart rate because both doses could peak at or near the same time. b. Interview with LPN #1 on 5/20/15 at 12:15 PM revealed the resident had his/her blood pressure (BP) checked one time per month unless there was an incident requiring more frequent monitoring. c. Medical record review showed the last BP taken for the resident was on 5/18/15 and was shown to be 130/80. Review of the facility's vitals summary report showed the resident's BPs were outside of normal parameters 16 out 29 times that were recorded since August 2014. These BPs ranged from 102/46 to 138/80 and a time of day was not recorded to show when the BPs were obtained. According to Smith, Duell, Martin "Clinical Nursing Skills Seventh Edition" on page	F 333	C. All nursing staff will be educated on the importance of clarifying specific time frames of medication administration. The Nursing Director or designee will perform ongoing monthly audits to ensure that professional standards are followed during medication pass. D. The Nursing Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	

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F 333	Continued From page 13 257, "A normal blood pressure in an adult varies between 100 mm Hg (millimeters of mercury) and 120 mm Hg systolic and 60 mm Hg and 80 mm Hg diastolic..." d. Interview with the administrator on 6/20/15 at 5:20 PM revealed blood pressure monitoring was done per physician order. Further the DON confirmed there was no way for the facility to ensure the resident's blood pressure was safe without monitoring. Additionally, the doses were administered too close together, and when the facility changed the time of the first dose to accommodate the resident they should have changed the time of the second dose as well.	F 333		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of menus, the facility failed to ensure therapeutic diets were provided as ordered for 2 of 4 sample residents (#8, #50) with therapeutic diets. The findings were: 1. Review of the 2/24/15 quarterly MDS assessment showed resident #8 had diagnoses that included dementia, and required supervision and set-up help for eating. Review of the 8/22/14 speech therapy consultation report showed the resident had a swallow evaluation completed and the recommendation was "alternating sour bolus liquid, lemon water with bites of food to improve sensory. Patient can remain on thin liquids but	F 367	F 367 The facility shall ensure that therapeutic diets are provided as ordered for residents. A. All nursing and nutrition staff will be instructed to ensure that the therapeutic diet is provided as ordered by physician's orders for resident #8. A. All nursing and nutrition staff will be instructed to ensure that the therapeutic diet is provided as ordered by physician's orders for resident #50. B. All residents have the potential to be affected by failure to ensure that therapeutic diets are provided as ordered by the physician. C. All nursing and nutrition staff will be educated on the	

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F 367	Continued From page 14 should be put on a mechanical soft diet with assistance at meals (cues to swallow and eat). Review of the May 2015 physician recapitulation of orders showed the resident had orders for the sour bolus and the mechanical soft diet. The following concerns were identified: a. Observation on 5/20/15 at 12 PM showed the resident was not provided or attempted to be provided the sour bolus. Additionally, the resident was served a regular texture meal of 1/2 of a cheeseburger on a bun, and sweet potato fries which appeared to be crispy. b. Review of the menu for the 5/20/15 lunch meal showed those with mechanical texture diets were to receive ground meat for either of the options which were a cheeseburger or baked ham. In addition, the "sweet potato fries" which was part of the cheeseburger meal were shown on the mechanical diet as 1/2 cup of sweet potato. Observation in the kitchen on 5/20/15 at 11:20 AM showed ground hamburger and ground ham had been prepared and were available to be served. c. Interview with the interim dietary director on 5/20/15 at 12:10 PM verified the diet order should be followed. The resident should have been served the mechanical ground hamburger and the sweet potato as shown on the menu. 2. Review of the May 2015 physician recapitulation of orders showed resident #50 had orders for thickened liquids and a mechanical soft diet. Review of the menu for the 5/20/15 lunch meal showed those with mechanical texture diets were to receive ground meat for either of the options which were a cheeseburger or baked ham. Observation of the meal service line on 5/20/15 at 11:20 AM showed ground ham was available to be served. Observation on 5/20/15 at	F 367	importance of ensuring that therapeutic diets are followed during the meal service as ordered by the physician. The Nutrition Services Director or designee will perform ongoing monthly audits to ensure that all therapeutic diets are followed during the meal service. D. The Nutrition Services Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	

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F 367	Continued From page 15 12 PM showed the resident had been served ham with augratin potatoes and steamed vegetables. The ham was not the mechanical ground texture instead it was cut into bite size pieces on the plate. Interview with the interim dietary director on 6/20/15 at 12:10 PM verified the resident should have been served the mechanical ground ham that was prepared to meet the requirements of that diet order.	F 367		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (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 and staff interview, the facility failed to ensure kitchen equipment and resident adaptive dining equipment was maintained in a sanitary manner. The findings were: 1. Observation on 6/18/15 at 11 AM showed a ceiling vent and tiles surrounding the vent were soiled with dark colored dust and grease. The vent was located in a food production area of the kitchen. In addition, the fans, fan covers, and ceiling surrounding the fans of the walk-in-refrigerator condenser unit were soiled	F 371	F 371 The facility shall ensure that kitchen equipment and resident adaptive dining equipment are maintained in a sanitary manner. 1. A. The ceiling vent and tile surrounding the vent will be cleaned and maintained in a sanitary manner. A. The fans and ceiling surrounding the fans of the walk-in-refrigerator condenser will be cleaned and maintained in a sanitary manner. B. All residents, staff, and visitors have the potential to be affected by failure to maintain kitchen equipment in a sanitary manner. C. All nutrition staff has been educated on 6/3/15 on cleaning	

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F 371	Continued From page 16 with black grease and dust. These conditions remained when observed on 5/20/15 at 11:20 AM. Interview with the interim dietary director on 5/20/15 at 11:20 AM verified these areas required cleaning. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(AC) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 5/18/15 at 12:10 PM showed adaptive long plastic drinking straws were stored on 2 resident dining tables in the main dining room. Continued observation showed the straws were used in specific cups to allow residents who were unable to hold the cup to drink independently with the cup remaining on the table. The straws which were stored at the tables were upright in a container and had no covering, and the straws were stored at the tables between meals. Observation on 5/20/15 at 11 AM showed 5 of the re-usable long plastic straws were stored near the beverage station in the kitchen. These straws were available for use on a tray, were not covered, or stored upright. Interview with the interim dietary director on 5/20/15 at 11:20 AM verified these adaptive straws were sanitized after use; however, the storage method may not ensure cleanliness or sanitation between uses. According to Food Code 2013, U.S. Public Health Service: 4-903.11 (A) Except as specified in ¶ (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored:	F 371	all kitchen equipment and the importance of maintaining sanitation. The Nutrition Services Director or designee will perform ongoing monthly audits to ensure all kitchen equipment is cleaned and sanitized. D. The Nutrition Services Director will aggregate monthly data and will report results to the Administrator, Care Center Medical Director, and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. 2. A. All resident adaptive dining equipment will be stored in a method to ensure cleanliness and sanitation between uses. B. All residents have the potential to be affected by failure to store adaptive dining equipment in a clean and sanitary manner.	

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F 371	Continued From page 17 (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under ¶ (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted 3. Observation on 5/18/15 at 11 AM and on 5/20/15 at 11:20 AM showed 9 plastic food/beverage pitchers which were located on a storage shelf. These containers were noted to be in poor condition with cracks and fissures in the plastic not allowing for effective cleaning/sanitation. Interview with the interim dietary director on 5/20/15 at 11:20 AM verified these items needed to be replaced. According to Food Code 2013, U.S. Public Health Service: 4-101.11 "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." F 428 483.60(a) DRUG REGIMEN REVIEW, REPORT	F 371 F 428	C. All nutrition staff has been educated on 6/3/15 on storing resident adaptive dining equipment in a clean and sanitary manner. The Nutrition Services Director or designee will perform ongoing monthly audits to ensure all resident adaptive dining equipment is stored appropriately. D. The Nutrition Services Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15 F 428 The facility shall ensure that the monthly medication regimen reviews finding potential irregularities by the pharmacist will be reported to the attending physician.	

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F 428 SS=D	Continued From page 18 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 observation, medical record review, and staff interview, the facility failed to ensure the monthly medication regimen reviews (MRRs) for 1 non-sample resident (#74) identified potential irregularities. The findings were: Observation of medication administration for resident #74 on 5/18/15 at 3:18 PM showed the resident was administered Labetalol (a blood pressure medication) 200 mg 1 tablet by mouth. Review of the medical record revealed the medication was ordered by a physician to be given BID (two times per day). Further review showed the medication had been changed in August 2014 from an administration times of AM and PM to Noon and PM. The following concerns were identified: a. Review of the MMR dated 8/31/14 showed the medication was changed related to the resident "sleeps until about noon everyday." b. Review of the MMR for August 2014 through April 2015 showed no recommendations were made to the physician about the medication	F 428	A. All pharmacists will be instructed to report the monthly medication regimen reviews finding potential irregularities to the attending physician and the Director of Nursing. including NPs + PAs B. All residents have the potential to be affected by not reporting potential irregularities found during the monthly medication regimen reviews. C. All pharmacists will be educated to report the monthly medication regimen reviews finding potential irregularities to the attending physician, the Pharmacy Director, and Nursing Director. All pharmacists will also be educated to visually inspect and verify the medication administration record to note appropriateness of medication administration times. The Pharmacy Director or designee will perform ongoing monthly audits to ensure the monthly medication regimen reviews finding potential irregularities are reported to the attending physician and the Nursing Director. Furthermore, that visual inspection and verification of the medication administration record to note appropriateness of medication administration times has occurred.	

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F 428	Continued From page 19 being administered at noon and PM or that the medications may be administered too closely together. c. Interview with the facility Pharmacist on 5/20/15 at 12:20 PM revealed the intent of BID medication administration is greater than 3 hours between doses. The interview further revealed that the medication being administered at noon and again at 3:18 PM had a potential risk of low heart rate and both doses could peak at or near the same time.	F 428	D. The Pharmacy Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	
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 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	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. 1. A. RN #1 will be instructed regarding the need to clean and sanitize the glucometer and allow the glucometer to remain wet with the cleansing solution for 2 minutes between resident use and before storing. B. All residents have the potential to be affected by failure to provide a safe, sanitary and comfortable environment and to help	

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

PRINTED: 06/05/2015
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
	560045	A. BUILDING _____ B. WING _____	06/21/2015

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 20 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, medical record review, policy and procedure review, and staff interview, the facility failed to ensure 3 random foam positioning devices were cleanable. In addition, the facility failed to ensure infection control practices were followed related to glucose testing for 2 residents (#77, #25). The findings were: 1. Observation of finger stick blood sugar on 6/18/15 at 3:40 PM showed RN #1 applied gloves and obtained a blood sample to test the blood glucose level for resident #77. After obtaining the sample, the nurse returned to the medication cart and without having cleaned/sanitized the device, set the glucometer on top of the cart. Continued observation showed the nurse then used the glucometer to obtain a finger stick blood sugar for resident #25. The glucometer was not cleaned or sanitized prior to obtaining the finger stick blood sugar for resident #25. The nurse then returned to the medication cart and wiped the glucometer with a "Super Sani-wipe" for less than 30 seconds. Interview with RN #1 on 6/18/15 at 4:15 PM revealed the glucometer was to be cleaned	F 441	prevent the development and transmission of disease and infection. 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 resident use and before storing. The Nursing Director or designee will perform ongoing monthly random audits to ensure nursing staff is allowing the glucometer to remain wet with the cleansing solution for 2 minutes prior to resident use and before storing. D. The Nursing Director will aggregate monthly data and will report results to the Administrator, Care Center Medical Director, and to the Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance.	

PRINTED: 08/05/2015
FORM APPROVED
OMB NO. 0938-0391

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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 _____	06/21/2015

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 21 after each resident use. Interview with the administrator and infection control nurse on 6/21/15 at 9:40 AM confirmed the nurse should have cleaned the glucometer after each resident use. Review of the facility policy "Waived Laboratory Testing" revised 4/15 on page 6 of 15, section 8 revealed "Clean the instrument between each use, following these guidelines carefully, to help obtain the best performance possible:...b. gently wipe the meter's surface using a Super Sani-cloth germicidal disposable cloth...g. Allow surface of the meter to remain damp with the germicidal solution for 2 minutes before drying completely." 2. Observation of resident #24 on 6/18/15 at 12:10 PM showed the resident was laying back in a geri-chair (recliner style wheel chair) in the dining room with a foam positioning device covering the entire length of the chair. The foam was exposed without any covering other than a sheep skin blanket and was porous and absorbent if in contact with fluids. Observation on 6/21/15 at 9:15 AM showed a foam positioning device in room 203 which was stained and discolored. The foam was exposed with no type of protective covering. Continued observation at that time showed a foam positioning device in room 410 with no type of protective covering. Interview with the infection control nurse on 6/21/15 at 9:40 AM revealed the facility should not use these foam style positioning devices due to the inability to clean and sanitize them appropriately.	F 441	2. A. All nursing staff will be instructed that foam positioning devices will not be used due to the inability to clean and sanitize them appropriately. 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. C. Education will be provided to the nursing staff regarding the non-use of foam positioning devices due to the inability to clean and sanitize them appropriately. The Nursing Director or designee will perform ongoing monthly random audits to ensure nursing staff is not using foam positioning devices.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2015
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
	536046	A. BUILDING _____ B. WING _____	05/21/2015

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 20 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, medical record review, policy and procedure review, and staff interview, the facility failed to ensure 3 random foam positioning devices were cleanable. In addition, the facility failed to ensure infection control practices were followed related to glucose testing for 2 residents (#77, #26). The findings were: 1. Observation of finger stick blood sugar on 5/18/15 at 3:40 PM showed RN #1 applied gloves and obtained a blood sample to test the blood glucose level for resident #77. After obtaining the sample, the nurse returned to the medication cart and without having cleaned/sanitized the device, set the glucometer on top of the cart. Continued observation showed the nurse then used the glucometer to obtain a finger stick blood sugar for resident #26. The glucometer was not cleaned or sanitized prior to obtaining the finger stick blood sugar for resident #26. The nurse then returned to the medication cart and wiped the glucometer with a "Super Sani-wipe" for less than 30 seconds. Interview with RN #1 on 5/18/15 at 4:15 PM revealed the glucometer was to be cleaned	F 441	F 441 Cont. D. The Nursing Director will aggregate monthly data and will report results to the Administrator, 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 6/30/15	