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 _____	10/04/2007

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 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure there was an individualized program of meaningful activities for 3 (#80, #82, #87) of 4 sample residents in the secure unit. The findings were: 1. Review of the 7/3/07 care plan for resident #87 revealed participation in activities was a concern. However, there were no measurable goals in the resident ' s plan of care to address the problem of activities. Observation on 10/2/07 from 8:15 AM until 11:30 AM (3 hours and 15 minutes) revealed resident #87 received no activity interventions and was not encouraged by staff to participate in any meaningful activities. According to the resident's record, s/he had been placed on a one-to-one activity program. However, according to the one-to-one activity log for September 2007, the resident received only four one-to-one interventions during that entire month. The actual content of the activities provided and the assessment of the effectiveness of the interventions were not documented. 2. Continuous observation on 10/2/07 from 8:15 AM until 11:30 AM and from 1 PM until 4:30 PM revealed resident #82 spent only 5 minutes (from 10:40 to 10:45 AM) involved in any sort of	F 248	F248 The facility shall ensure that an ongoing program of activities is designed to meet in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident by: A.1. Activities Director will re-assess resident #87 and include measurable goals in the plan of care to address the activity problem. The Activities Director will re-assess this resident initially, quarterly, annually, and as needed. Content of activity provided and the assessment of the effectiveness of the interventions will be documented. A.2. Activities Director will re-assess resident #82 and include measurable goals in the plan of care to address the activity problem. The Activities Director will re-assess this resident initially, quarterly, annually, and as needed. Content of activity provided and the assessment of the effectiveness of the interventions will be documented. A.3. Activities Director will re-assess resident #80 and include measurable goals in the plan of care to address the activity problem. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10-29-07

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.

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F 248	Continued From page 1 meaningful activity. Review of the current (5/1/07) care plan revealed activities was identified as a problem area for this resident. Further review of the care plan showed there were no measurable goals identified to address this problem. Review of the resident's care plan also revealed the resident was placed on a one-to-one program in order to address the deficits in this resident's activity involvement. However, review of the one-to-one activity log for September 2007 revealed the resident received only four one-to-one activities during the entire month. 3. Review of the 7/3/07 care plan for resident #80 revealed activities was identified as a problem area. Further review established that there were no measurable activity goals identified. Review of the plan of care also revealed the resident was placed on a one-to- one program for activities. Continuous observation on 10/2/07 from 8:15 AM until 11:30 AM and from 1 PM until 4:30 PM revealed resident #80 only participated in activities from 10:17 AM until 10:45 AM (a total of 28 minutes). Observation showed the resident was not involved or encouraged to participate in any other activities throughout the 6.5 hour period. Review of the one-to-one activity records for September 2007 revealed the resident only received six one-to-one activity interventions during that entire month. 4. Interview with registered nurse (RN) #1 and licensed practical nurse (LPN) #2 on 10/3/07 at 3:15 PM revealed activities were not routinely offered to residents in the secure unit. Both nurses stated they thought the residents would enjoy more involvement in activities. Interview with the activity director on 10/3/07 at 4:30 PM revealed the activities department staff were all	F 248	Activities Director will re-assess this resident initially, quarterly, annually and as needed. Content of activity provided and the assessment of the effectiveness of the interventions will be documented. B. All residents have the potential to fall under the lack of meaningful activities. The activities department will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well-being of each resident. When appropriate to include non activities C. The residents of the special care unit will have their own specialized monthly calendar. The Activities Director also has changed the documentation for this special unit to ensure the residents leisure pursuits are met. She has inserviced her activities staff to these comprehensive and appropriate changes. E D. Activities Director will monitor the specialized monthly calendar and the comprehensive documentation process. This process will be aggregated quarterly by the Activities Director and D. Activities staff	

primary Responsibility will be to provide activities & NOT direct care.

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F 248	Continued From page 2 certified nurse aides (CNAs) and were utilized to provide direct care at times, and therefore were unable to conduct the activities that were scheduled. She also stated there was no official plan or activity calendar for residents in the special care unit.	F 248	reported to the Vice President of Resident Care Services, the Medical Director, and the Quality council.	11-16-07
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272	F272 The facility will ensure that a comprehensive assessment of each resident is performed initially, quarterly, and as needed. This will be accomplished by: A.1. A comprehensive sleep assessment will be completed on Resident #72 by the nursing director. A.2. No further action, resident #91 is a closed record. A.3. A comprehensive sleep assessment will be completed on Resident # 74 by the nursing director. A.4. A comprehensive safety and restraint assessment will be completed on Resident # 77 by the restorative nurse. A.5. A comprehensive safety and restraint assessment will be completed on Resident #68 by the restorative nurse. A.6. A comprehensive sleep assessment will be completed on Resident # 27 by the nursing director. A.7. A comprehensive safety and restraint assessment will be completed on Resident # 37 by the restorative nurse.	

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F 272	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to complete a comprehensive assessment of needed areas for 7 (#27, #37, #68, #72, #74, #77, #91) of 18 sample residents. The findings were: 1. Review of physician orders showed on 1/21/05 resident #72 was ordered Restoril (sedative-hypnotic) 15 milligrams (mg) at bedtime. Review of the August and September 2007 medication administration records (MARs) showed the resident received the medication every night. Review of a 7/22/07 physician progress note showed the resident had insomnia. However, review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, etc. During an interview on 10/3/07 at 4:15 PM director of nursing (DON) #1 stated there was no comprehensive sleep assessment. 2. Review of physician orders showed on 6/6/07 resident #91 was ordered Ambien CR (sedative-hypnotic) 6.25 mg at bedtime as needed for insomnia. Review of the 2007 MARs showed the resident received the medication every night except one in July, every night in August, and every night except one in September. Review of the care plan dated 9/4/07 showed the resident requests a sleeping pill every night. However, review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine	F 272	B. All residents have the potential to be affected by the lack of comprehensive assessments. C.1.All residents will have initial comprehensive assessments to include sleep assessments/sleep patterns. Follow up assessments will be completed quarterly and as needed. Frequency of hypnotics will be assessed and reported to the physician for evaluation of continued use. Nursing will complete sleep assessment/sleep pattern assessment. Pharmacy will monitor hypnotic use and report to physician. C.2.All residents currently using physical restraints or being considered for physical restraints will have a restraint assessment in addition to a comprehensive assessment. Restraint assessments will be completed initially, quarterly, and as needed. The restorative nurse will complete the restraint assessment. C.3. All residents will receive safety assessments, in addition to comprehensive assessments, initially, quarterly, and as needed. The restorative nurse will complete the safety assessment.	

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F 272	Continued From page 4 the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, etc. During an interview on 10/3/07 at 4:15 PM, DON #1 stated there was no comprehensive sleep assessment. 3. Review of physician orders showed on 4/15/04 resident #74 was ordered Pamelor (antidepressant) 10 mg at bedtime for insomnia. In addition, on 5/3/07 the physician ordered Melatonin 1 mg as needed for insomnia. Review of the August and September 2007 MARs showed the resident received the Pamelor every night and the Melatonin three times each month. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, depression, etc. During an interview on 10/3/07 at 4:15 PM, DON #1 stated there was no comprehensive sleep assessment. 4. Review of the 2/27/06 initial, the 2/26/07 annual and the 5/29/07 quarterly Minimum Data Set (MDS) assessments for resident #77 revealed s/he had no restraints. However, observation on 10/2/07 from 9:30 AM until 11:30 AM revealed the resident was in his/her room in a recliner which was in the reclined position with the foot rest up. The following concerns were identified: a. Interview with registered nurse (RN) #1 on 10/3/07 at 1:30 PM revealed the resident was not able to get out of the recliner on his/her own when it was in the reclined position. The RN stated the resident was able to get out of the	F 272	D. Completion results of the sleep assessment, safety, restraint, and physical assessments will be aggregated quarterly and be reported to the Vice President of Resident Care Services, Medical Director, and Quality Council.	11-16-07

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F 272	Continued From page 5	F 272		

recliner when it was not in the reclined position. The RN also stated the resident was often placed in the recliner during the daytime because s/he had frequent falls and because the resident's yelling out irritated other residents when s/he was left in the wheelchair in the dayroom.

b. Although there were less restrictive alternatives for fall prevention utilized, there was no evidence a restraint assessment was performed for this resident.

5. Review of the 4/15/07 at 1:40 AM quality improvement fall follow-up report for resident #68 revealed s/he was found on his/her back hanging from the bed with the left thigh partially pinned under the bottom split side rail. Further review of the report revealed the fall committee recommended placing a personal alarm on the resident and for body pillows for positioning. However, review of the entire medical record revealed there was no evidence a safety assessment of the side rails and mattress was performed. During an interview with DON #1 on 10/4/07 at 11 AM, s/he confirmed no safety assessment was completed.

6. Review of resident #27's medical record revealed s/he was prescribed melatonin as a sleep aid. The current MAR showed the resident was receiving melatonin each evening. The record failed to include evidence the resident had been assessed for his/her sleep habits or that other interventions had been investigated as an alternative to medication. During an interview on 10/3/07 at 4:15 PM, DON #1 stated there was no comprehensive sleep assessment.

7. Multiple observations of resident #37 from 10/1/07 through 10/3/07 revealed s/he routinely

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F 272	Continued From page 6 had a lap buddy (cushioned lap tray) on his/her wheelchair. Observation on 10/1/07 at 6:07 PM revealed when the lap buddy was removed, the resident scooted forward in the chair, and staff needed to be positioned directly in front of the resident to keep the resident in the wheelchair. Review of the resident's medical record on 10/3/07 showed s/he was not coded as having a restraint in place, nor had the resident been assessed for a physical restraint. A fall risk assessment dated 5/1/07 indicated the lap buddy was "...for positioning...", but failed to consider the device as a physical restraint. The MDS coordinator reiterated in an interview on 10/4/07 at 9:20 AM the lap buddy on resident #27's wheelchair was regarded as a positioning device by the facility, and not a restraint. However, she acknowledged the resident could leave his/her chair if the lap buddy were not in place.	F 272		
F 315 SS=D	483.25(d) URINARY INCONTINENCE 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, staff interview, and medical record review, the facility failed to ensure an indwelling catheter was not utilized without a medical reason for one (#68) of two sample	F 315		

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F 315	Continued From page 7 residents who had catheters. The findings were: Review of the 2/26/07 initial Minimum Data Set (MDS) assessment for resident #68 revealed s/he was admitted with an indwelling catheter post operatively after sustaining a hip fracture. Review of the 4/16/07 significant change MDS assessment and the 7/16/07 MDS assessment revealed the resident still had an indwelling catheter. Observation on 10/3/07 (seven months post operatively) revealed the resident continued to have the catheter. Review of the entire medical record revealed no evidence of a medical reason for the resident to continue having the indwelling catheter. Interview with director of nursing (DON) #1 and RN #4 on 10/4/07 at 11:20 AM revealed they thought the reason for the catheter was because the resident was difficult to transfer and required a mechanical lift.	F 315	F315 The facility will ensure that a comprehensive assessment of each resident is performed initially, quarterly, and as needed. This will be accomplished by: A. Resident # 68 has been reassessed for need of an indwelling catheter by primary physician. Indwelling catheter discontinued on 10/9/07. B. All residents have the potential to be affected by the use of indwelling catheters without medical necessity. C. All residents with indwelling catheters will be assessed initially, quarterly, and as needed for medical necessity by the bowel & bladder nurse. D. Assessment to ensure medical necessity for the presence of indwelling catheters will be aggregated quarterly and be reported to the Vice President of Resident Care Services, Medical Director, and Quality Council.	11-16-07
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident 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 review of Material Safety Data Sheets (MSDS), the facility failed to ensure a safe environment was provided and maintained in one (secure unit) of three nursing units. The findings were:	F 323	Nursing coordinators	

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F 323	Continued From page 8 Observation on 10/2/07 from 10:27 AM until 10:30 AM revealed a housekeeping cart was left unattended outside of the dining room in the secure unit. Observation on 10/3/07 from 8:30 AM until 8:57 AM (27 minutes) revealed the housekeeping cart was again left unattended outside of resident rooms #214 and #215 in the secure unit. During the observations, residents were walking about on the unit. Observation revealed both times the cart had the following hazardous chemicals sitting on top of the cart, which were accessible to cognitively impaired residents: a. One bottle of OASIS heavy duty acid bathroom cleaner. Review of the MSDS revealed the liquid was dangerous, was harmful and potentially fatal if swallowed, and could cause respiratory tract, eye and skin burns. The MSDS instructed that ingestion or contact would require " ...medical attention immediately." b. Two bottles of OASIS toilet bowl cleaner. Review of the MSDS revealed the liquid was dangerous, was harmful if swallowed, could cause eye burns, and skin and respiratory tract irritation. "Get medical attention immediately." c. One bottle of OASIS ammoniated glass cleaner. Review of the MSDS revealed the liquid could cause severe eye irritation, respiratory tract and skin irritation, and was combustible. The MSDS instructed that ingestion or contact would require " ...medical attention immediately." d. One bottle of OASIS multi-quat sanitizer. Review of the MSDS revealed the liquid was harmful if swallowed, and could cause respiratory, eye and skin burns. The MSDS instructed that ingestion or contact would require " ...medical attention immediately." e. One bottle of antibacterial all purpose cleaner. Review of the MSDS revealed the liquid	F 323	F323 The facility will ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. A. The housekeeping department staff will maintain the housekeeping cart to eliminate resident accessibility to all hazardous chemicals. B. All residents have the potential to be affected by failing to maintain hazardous chemicals. C. The housekeeping department Director shall inspect weekly all areas to assure compliance in providing a safe environment for all residents. Additionally, all housekeeping staff shall be in serviced in regards to assisting with providing a safe environment. D. The housekeeping department Director shall provide written documentation of safety inservices to the Director of the Safety committee, who in turn will provide an aggregated report to the Safety committee. Inspection Reports 11-16-07	

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F 323	Continued From page 9 was dangerous, harmful if absorbed through the skin or if swallowed, was combustible, and the vapor could cause a flash fire. The MSDS instructed that ingestion or contact would require " ...medical attention immediately." f. One bottle of Pro Link urine stain remover. Review of the MSDS revealed the product could cause nausea, vomiting, diarrhea, irritation to the nose, throat, and respiratory tract, and sever irritation, pain, and transient corneal injury to the eyes. Interview with the housekeeper on 10/2/07 at 10:31 AM revealed she was aware that she was not supposed to leave the cart unattended.	F 323		
F 326 SS=D	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of menus, and staff interview, the facility failed to ensure a therapeutic diet was provided as ordered by the physician for one (#51) of four sample residents for whom therapeutic diets were ordered. The findings were: Review of a nursing communication to the physician dated 8/15/07 showed resident #51 had 3+ to 4+ pitting edema to the left lower extremity. On 8/15/07, the physician ordered a low sodium diet due to the edema. On 8/30/07 the physician ordered JOBST stockings for	F 326	F326 The facility will ensure that all residents receive a therapeutic diet when there is a nutritional problem. A. Resident #51 will be served the correct therapeutic diet, as ordered by the physician, by nursing and dietary staff. B. All residents have the potential to be affected by not receiving the correct therapeutic diet. C. Dietary tech will notify kitchen staff of all diet changes. Diet sheets will be reviewed and printed weekly. Dietary and nursing staff will be educated that nursing staff must state the resident's name when ordering his or her meal. D. Aggregated results of diet sheet reviews and random audit of staff accuracy when ordering residents meals will be monitored by Maren Fross. Results will be reported quarterly to the Vice President of Resident Care Services, Medical Director and Quality Council.	11-16-07

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F 326	Continued From page 10 edema. Observation on 10/2/07 at 9 AM revealed the resident wore a JOBST stocking on the left lower extremity; a family member commented it was for edema. The following concerns were identified: a. Review of the menu for the evening meal on 10/2/07 showed residents on a low sodium diet were to receive carrots instead of creamed cabbage. Observation of trayline in the kitchen on 10/2/07 at 5:45 PM revealed staff served creamed cabbage to resident #51. A list of the residents and their diets were posted in the kitchen. This resident was listed as receiving a " regular diet. " b. During an interview on 10/3/07 at 9:40 AM, the dietary manager verified the resident's diet order according to kitchen records was a "regular diet." The dietary manager stated she and the kitchen staff were unaware the physician had ordered a low sodium diet for this resident on 8/15/07.	F 326		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	F329 The facility will ensure that each resident's drug regimen will be free from unnecessary drugs by: A.1. Resident # 72 will have a medication evaluation completed by the pharmacist and sleep assessment. A sleep assessment will be completed by the nursing director. The care plan will be revised to include the problem of insomnia with non-pharmacological interventions. All nursing staff will be inserviced about documenting non-pharmacological interventions before administering ~~anti-psychotic~~ psychotropic drugs. A.2. Resident # 91 is a closed record.	

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F 329	Continued From page 11 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure drug regimens for 4 (#27, #72, #74, #91) of 18 sample residents were free of unnecessary medications. The findings were: 1. Review of physician's orders dated 1/21/05 revealed 15 mg of Restoril at bedtime was ordered for resident #72. Review of the August and September 2007 medication administration records (MARs) showed the resident received the medication every night. Review of a 7/22/07 physician's progress note showed the resident had a diagnosis of insomnia. Review of the medical record revealed no evidence that a comprehensive sleep assessment had ever been completed in order to determine the resident's usual sleep pattern and possible reasons for insomnia, such as noise, pain, side effects of medication, stress, depression, etc. Review of the care plan dated 9/18/07 showed "insomnia" was not identified as a concern for this resident. Further review of the medical record lacked evidence non-pharmacological interventions were tried to address the resident's sleep issues. During an interview on 10/3/07 at 4:15 PM director of nursing (DON) #1 verified there had	F 329	A.3. Resident # 74 will have a medication evaluation completed by the pharmacist and sleep assessment. A sleep assessment will be completed by the nursing director. The care plan will be revised to include the problem of insomnia with non-pharmacological interventions. All nursing staff will be inserviced about documenting non-pharmacological interventions before administering ~~anti-psychotic~~ psychotropic drugs. A.4. Resident # 27 will have a medication evaluation completed by the pharmacist and sleep assessment. A sleep assessment will be completed by the nursing director. The care plan will be revised to include the problem of insomnia with non-pharmacological interventions. All nursing staff will be inserviced about documenting non-pharmacological interventions before administering ~~anti-psychotic~~ psychotropic drugs. B. All resident's have the potential to be affected by the use of unnecessary drugs. C. All residents on ~~anti-psychotics~~ psychotropic will have a medical evaluation completed by a pharmacist initially, quarterly	

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F 329	Continued From page 12 been no comprehensive sleep assessment conducted for this resident. 2. Review of physician's orders dated 6/6/07 revealed 6.25 mg of Ambien CR was ordered for resident #91 at bedtime as needed for insomnia. Review of the 2007 MARs showed the resident received the medication every night except one in July, every night in August, and every night except one in September. Review of the care plan dated 9/4/07 showed the resident requested a sleeping pill every night. Review of the medical record revealed no evidence a comprehensive sleep assessment was ever completed for this resident in order to determine his/her usual sleep pattern/disturbance and possible reasons for insomnia. The medical record lacked evidence other non-pharmacological interventions were tried to address this resident's sleep issues. During an interview on 10/3/07 at 4:15 PM, DON #1 verified the facility had not conducted a comprehensive sleep assessment for this resident. 3. Review of a physician's order written on 4/15/04 revealed 10 mg of the antidepressant, Pamelor, was ordered at bedtime for insomnia for resident #74. In addition, on 5/3/07 the physician ordered Melatonin 1 mg as needed for insomnia. Review of the August and September 2007 MARs showed the resident received the Pamelor on a nightly basis and the Melatonin three times each month. Review of the medical record revealed no evidence a comprehensive sleep assessment had been conducted for this resident. Review of the care plan dated 7/19/07 revealed insomnia was not identified as a care issue for this resident. Review of the medical record failed to show any evidence other	F 329	and as needed. Residents currently taking sleep medications will receive a sleep assessment. Prior to initiating sleep medication, residents will also receive sleep assessments. Care plans will accurately reflect non-pharmacological interventions for those residents with insomnia. D. Random audits to ensure that medication evaluation, sleep assessment, and care plan revision are completed will be monitored by MDS Director. Results will be reported to the Vice President of Resident Care Services, Medical Director, and Quality council.	11-16-07

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F 329	Continued From page 13 non-pharmacological interventions had been tried. During an interview on 10/3/07 at 4:15 PM, DON #1 stated there had been no comprehensive sleep assessment conducted for this resident. 4. Medical record review revealed melatonin was prescribed for resident #27 as a sleep aid. The current MAR showed the resident was receiving melatonin on a nightly basis. The record failed to include evidence the resident had been assessed for his/her sleep habits or that other interventions had been investigated as an alternative to medication. During an interview on 10/3/07 at 4:15 PM, DON #1 verified that there had been no comprehensive sleep assessment for this resident.	F 329		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334	F334 The facility will ensure that policies and procedures are in place to include education regarding the benefits & potential side effects of the influenza immunization prior to administration. The facility will ensure that policies and procedures are in place to include education regarding the benefits & potential side effects of the pneumoccocal immunization prior to administration. The facility will ensure that the resident and or the resident's legal representative is provided education regarding the benefits & potential side effects of all immunizations prior to administration. A.1. Resident # 69 or legal representative will be provided education regarding the benefits & potential side effects of the	

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F 334	Continued From page 14 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal	F 334	influenza immunization prior to administration. The education provided will be documented in the resident's chart. A.2. Resident # 72 or legal representative will be provided education regarding the benefits & potential side effects of the influenza immunization prior to administration. The education provided will be documented in the resident's chart. A.3. Resident # 74 or legal representative will be provided education regarding the benefits & potential side effects of the influenza immunization prior to administration. The education provided will be documented in the resident's chart. A.4. Resident # 77 or legal representative will be provided education regarding the benefits & potential side effects of the influenza immunization prior to administration. The education provided will be documented in the resident's chart. A.5. Resident # 82 or legal representative will be provided education regarding the benefits & potential side effects of the influenza immunization prior to administration. The education provided will be documented in the resident's chart.	

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F 334	Continued From page 15 representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of policies, and staff interview, the facility failed to develop and implement policies to assure education was provided prior to influenza immunizations for six (#34, #69, #72, #74, #77, #82) of six sample residents reviewed for immunization status. The findings were: Review of the facility's policy entitled "Documentation of Vaccines and TB Skin Tests," which was dated 6/2/07, showed education was not addressed. Review of medical records revealed the following concerns related to the lack of education: a. Resident #69 received an influenza immunization on 11/7/06, but there lacked evidence the resident and/or family received education of the benefits and risks. b. Resident #72 received an influenza immunization on 11/7/06, but there lacked evidence of education. c. Resident #74 received the influenza vaccine on 11/7/06, but there was no documentation that education was provided to the resident and/or family. d. Review of the medical record for resident #77 revealed s/he received the influenza vaccine on 11/6/06. There was no documented evidence, however, that education related to the influenza vaccine was provided to the resident or family. e. Review of the medical record for resident #82 revealed s/he received the influenza vaccine	F 334	A.6. Resident # 34 or legal representative will be provided education regarding the benefits & potential side effects of the influenza immunization prior to administration. The education provided will be documented in the resident's chart. B. All residents have the potential to be affected by the lack of education regarding immunizations. C. All residents or legal representatives will be provided education regarding the benefits & potential side effects of the pneumococcal influenza immunization prior to administration. The education provided will be documented in the resident's chart. All nursing staff have been educated regarding the requirement to provide education to the resident or legal representative prior to administration of the influenza and pneumococcal vaccine. Continued education to nursing staff will be provided during a monthly nursing meeting scheduled on November 14, 2007. D. A random audit to ensure that education has been provided and documented in the resident's chart will be conducted by the nursing director. The information will	

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F 334	Continued From page 16 on 11/2/06. Again, there was no evidence that education about the influenza vaccine was ever provided for the resident or family. f. Review of resident #34's medical record failed to reveal documentation that the resident had received education and understood the risks and benefits of influenza vaccination prior to receiving the vaccine on 10/30/06. During an interview with the two directors of nursing (DONs #1 and #2) on 10/3/07 at 10 AM, it was confirmed that education for immunizations for residents was not provided or documented. They also confirmed the facility did not have a policy that addressed the provision of education for residents and/or their families related to immunizations.	F 334	be aggregated quarterly and reported to the vice president of Resident Care Services, Medical Director and Quality council.	11-16-07
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	F356 The facility will ensure to post nurse staffing and current resident census information at the beginning of each shift. C. The nurse working on the South wing will be responsible for posting the nursing staffing & current resident census at the beginning of each shift. Nursing staff have been provided with education to ensure nurse staffing & current resident census are posted at the beginning of each shift. Follow-up education will be provided during a monthly nursing meeting scheduled on November 14, 2007. D. A random audit to ensure that the nurse staffing and	

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F 356	Continued From page 17 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post nurse staffing and census information at the beginning of each shift on 3 of 3 dates when the information was reviewed. The findings were: Observation on 10/2/07 at 11:15 AM revealed the nurse staffing was posted, but did not include the census. In addition, staffing information for both the evening shift (3 PM- 11 PM) and night shift (11 PM- 7 AM) had already been completed and posted. Observation on 10/3/07 at 10 AM again revealed the evening and night shift nurse staffing information was already posted. In addition, the posted information did not include the resident census. Observation on 10/4/07 at 8:50 AM revealed the nurse staffing posting still read "10/3/07." During an interview on 10/4/07 at 9:10 AM, DON #1 stated the night shift nurse was assigned to post all nurse staffing information for all shifts for the following day. Furthermore, the DON was aware the required resident census information was not posted.	F 356	current resident census information was completed accurately will be conducted by the nursing director. The information will be aggregated quarterly and reported to the Vice President of Resident Care Services, Medical Director and Quality council.	11-16-07

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F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted temperature logs, and staff interview, the facility failed to ensure all dishware was sanitized during 1 of 1 observation or that food preparation equipment in 3 of 3 nursing units was clean. The findings were: 1. Observation of the warewashing procedure on 10/3/07 from 9:15 AM until 9:25 AM revealed a dietary aide was operating the dish machine. During the observation, the gauge on the machine indicated the temperature for the sanitizing rinse cycle was between 135 and 140 degrees F. During the observation, the dietary aide washed approximately eight loads of dishes in the dish machine, but did not monitor the rinse temperature. A second dietary aide put the dishes away. Review of the posted temperature log showed no dish machine temperatures were logged for that date. Review of the manufacturer's written instructions for the dish machine showed the final rinse temperature was supposed to be at least 180 degrees F. Interview with the dietary manager on 10/3/07 at 9:30 AM revealed she was aware that the sanitizing rinse was supposed to be at least 180 degrees F. The dietary manager looked at the machine and determined the booster heater switch was in the "OFF" position. Once turned on, the rinse	F 371	F371 The facility will ensure that food will be stored, prepared, distributed, and served under sanitary conditions. B. All residents have the potential to be affected by the lack of storing, preparing, distributing and serving food under sanitary conditions. C.1. Nutrition Services Director inserviced dietary staff on the proper dish washing procedure for all dishes & utensils. The dish machine temperature logs are to include the position of the booster heater switch. C.2. The nursing directors educated all nursing staff that microwaves are to be cleaned every night and as needed on each of the Care Center units. D.1. Random audits of temperature logs will be conducted by Nutrition Services Director. The results will be aggregated quarterly and reported to the Vice President of Resident Care Services, Medical Director and Quality council. D.2. Random audits to check for microwave cleanliness will be conducted by the nursing director. The results will be aggregated quarterly and reported to the vice president of Resident Care Services, Medical Director, and Quality Council.	11-16-07

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temperature rapidly increased to 180 degrees F. The dietary manager stated staff assigned to the dish room were supposed to monitor and record the temperatures at the beginning of the dishwashing procedure. She confirmed staff had not checked the machine and were unaware that it was not operating properly. She further stated staff would repeat the dishwashing procedure for all dishes and utensils that had been washed that day to ensure they were sanitized.

According to the Food Code, U.S. Public Health Service, FDA, 2005, section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures: "...the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194 degrees Farenheit (F) or less than....180 degrees F."

2. The following concerns were identified regarding the microwave ovens:

a. Observation on 10/1/07 at 5 PM revealed the inside of the microwave oven on the north unit had splatters of dried food debris on the back and top. Observation again on 10/2/07 at 4:50 PM revealed the microwave was in the same condition.

b. Observation on 10/1/07 at 5 PM revealed the inside of the microwave on the south unit had dried food splatters on all surfaces. Observation on 10/2/07 at 10:30 AM showed the microwave was in the same condition.

c. Observation of the microwave in the secure unit on 10/2/07 at 4:52 PM revealed the inside had splatters of food debris on all surfaces.

d. During an interview on 10/3/07 at 9:40 AM, the dietary manager stated the dietary department was not responsible for the microwaves. On 10/4/07 at 9:10 AM, director of nursing (DON) #1 stated the night shift certified

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F 371	Continued From page 20 nurse aides (CNAs) were supposed to clean the microwaves. According to the Food Code, U.S. Public Health Service, FDA, 2005, section 4-601.11 "...nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	F387 The facility will ensure that residents will be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A.1. The primary physician of resident #80 will be notified by the Medial Director of the requirements to see the residents as scheduled. A.2. The primary physician of resident #82 will be notified by the Medial Director of the requirements to see the residents as scheduled. B. All residents have the potential to be affected by failing to assure that a physician or mid level practitioner visit occurs as scheduled. C. The vice president of Resident Care Services will provide each individual physician a schedule quarterly which indicates which of his or her residents need to be seen. D. Data will be aggregated and a percentage of compliance will be determined. The information will be submitted to the Medical Director and Quality Council.	11-16-07
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure physician visits were timely for two (#80, #82) of 18 sample residents. The findings were: 1. Review of the medical record for resident #80 revealed s/he was seen and examined by his/her physician on 3/1/07. Further review revealed the resident did not have another physician visit until 6/30/07, 120 days later. During an interview with director of nursing (DON) #1 on 10/4/07 at 11:20 AM, s/he confirmed the resident had not been seen by a physician or physician extender between 3/1/07 and 6/30/07. 2. Review of the medical record for resident #82 revealed s/he was seen and examined by his/her physician on 4/10/07. Further review revealed the	F 387		

Vice President of Resident Care Service

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F 387	Continued From page 21 resident was not seen or examined by his/her physician again until 7/10/07, 89 days later, instead of the federally required physician visit at least once every sixty days. During an interview with DON #1 on 10/4/07 at 11:20 AM, s/he confirmed the resident had not been seen by a physician or physician extender between 4/10/07 and 7/10/07.	F 387		
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES 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	F431 The facility will ensure to 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. A.1. Nursing staff will be instructed to place a handwritten note with reference to physician's current medication order and date on each medication that is changed for resident # 78. A.2. Nursing staff will be instructed to place a handwritten note with reference to physician's current medication order and date on each medication that is changed for resident # 86. B. All residents receiving medications from outside sources have the potential to be affected by lack of accurate medication labeling. C. All nursing staff will be educated to place a handwritten note with reference to physician's current medication order and date on each	

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	535045	A. BUILDING _____ B. WING _____	10/04/2007

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 431	Continued From page 22 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 accurate medication labeling for two (#78, #86) non-sample residents. The findings were: 1. Observation on 10/2/07 at 7:50 AM revealed one-half of a 5 mg tablet of Glyburide was administered to resident #78 for diabetes. Review of the medication bottle revealed it was labeled, "Glyburide 5 mg tab Take two tablets by mouth two times daily before meals for diabetes." Interview of RN #1 at the time revealed the physician had changed the order, but the label had not been changed by the resident's pharmacy. Review of the 10/07 physician's order recapitulation revealed the nurse administered the proper dosage; however, the label on the medication bottle was inaccurate. 2. Observation on 10/2/07 at 8:05 AM revealed one 25 mg tablet of Metoprolol Tartrate was administered to resident #86. Review of the medication bottle revealed it was labeled, "Metoprolol Tartrate 25 mg Take one-fourth (6.25 mg) tablet by mouth two times daily..." Interview of RN #1 at the time revealed the physician had changed the order, but the label had not been changed by the resident's pharmacy. Review of the 10/07 physician's order recapitulation revealed the nurse had administered the proper dosage; however, the label on the medication bottle was inaccurate.	F 431	medication change that is from an outside source. D. Random audits will be performed by the nursing director to ensure that medication labels are correct and that any dosage changes are reflected by a handwritten note referring to the change. E The Results will be aggregated to Vice President of Resident Care Service, Medical Director, and Quality Council	11-16-07

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F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure staff practiced appropriate hand hygiene during one of two meals observed. The findings were: 1. Volunteer #1 was observed on 10/2/07 at 7:45 AM serving food trays to residents in the main dining room. From 7:45 AM to 8:22 AM (37 minutes) the volunteer did not wash his/her hands. The following concerns were noted with regard to the volunteer's actions during this observation at the breakfast meal: a. While waiting in line to receive food trays, the volunteer scratched his/her head and rubbed his/her nose with his hand on multiple occasions; the volunteer was also observed probing the inside of his/her right ear with a finger. On one occasion s/he covered a cough with his/her right hand. b. While moving along the countertop at the serving window, the volunteer placed his/her hands palm down and ran them along the full length of the counter surface. The counter surface was routinely touched by all staff members in the serving line. c. While passing food to residents, the volunteer handled plates, utensils, and glassware by placing his/her hands and fingers onto surfaces	F 444	F444 The facility will ensure that all volunteers, students, and staff are required to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. A.1. Volunteer #1 was inserviced by the infection control nurse on hand washing & food preparation on October 3, 2007. A.2. Student nurse #1, remaining nursing students, and their instructor were inserviced by the infection control nurse on proper hand hygiene and food service on October 3, 2007. B. All residents have the potential to be affected by the lack of volunteers, students, and staff washing their hands after each direct resident contact. C.1. All volunteers will be inserviced by the infection control nurse on proper hand washing procedures. C.2. Nursing Director(s) will be responsible to ensure that nursing students have been educated on proper hand washing procedures. D. Random observation audit will be performed by the nursing director to ensure volunteers, students, and staff are following hand washing guidelines.	11-16-07

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F 444	Continued From page 24 likely to come into contact with residents' food. The volunteer delivered food and glassware to at least eight different residents during this meal observation. d. While assisting resident #19, the volunteer opened a small drink container by placing his/her fingers into the pour spout of the container. e. While assisting resident #74, the volunteer placed a thumb inside a drinking cup when lifting it from the table. The volunteer also picked up the resident's toast to spread jelly onto the bread. 2. During the same meal observation on 10/2/07, several nursing students were observed assisting in the dining room. Nursing student #1 was observed from 8:05 AM to 8:22 AM. The nursing student did not wash his hands during the 17 minute observation. From this observation, the following concerns were noted: a. The student routinely rubbed his face and chin with his right hand while talking with residents and staff. He used his right hand repeatedly to assist residents with their utensils and glassware. He lifted a drinking cup for resident # 3 by placing his right hand and fingers over the rim of the cup. b. The student wore a stethoscope around his neck and frequently touched the stethoscope at both the acoustic chestpiece and the ear pieces with his fingers. c. When adding cream to a cup of coffee, the student opened a common-use cream container by placing his finger inside the pouring spout of the container; he served this cup of coffee to resident #67. 3. The infection control nurse (ICN) stated in an interview on 10/3/07 at 2:30 PM her expectation was that all staff assisting with meals observe appropriate hand washing practices, in particular	F 444	E. The Results will be aggregated to the Vice President of Resident Care Service, Medical Director, and Quality Council	

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F 444	Continued From page 25 when touching food or items likely to come into contact with food. 4. The facility's policy on handwashing, EN-0016, last reviewed in April 2007, emphasized the role of handwashing as a principal tool of infection control and stated an expectation that all staff will "...have high standards for personal hygiene." The policy further required all staff to wash their hands "...before and after feeding patients/residents or preparing foods... (and)...between contacts with different patients/residents."	F 444		