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 _____	C 06/22/2017

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 A recertification survey was conducted by Healthcare Licensing and Surveys from 6/19/17 to 6/22/17. Also reviewed in the course of the survey was complaint intake WY000002427. 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 services MAR- Medication administration record MDS- Minimum Data Set LPN- Licensed practical nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 167	F 167 The facility must have reports with respect to any survey, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request and post notice of availability of such reports in areas of the facility that are prominent and accessible to the public. A. A notice has been posted with the current survey inspection report to inform residents, families, and visitors that reports from the 3 preceding years were available	

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

Rachelle Osborne BSN, RN, NHA — 7/17/17

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 167	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a notice was posted regarding the availability of survey inspection results for surveys conducted during the 3 preceding years. The findings were: Observation on 6/20/17 at 10:15 AM showed the current survey inspection report was available in a binder near the front lobby for all to read; however, there was no notice posted to inform residents, families and visitors that reports from the preceding 3 years were available. Interview with the administrator on 6/22/17 at 9:37 AM verified she was unaware of this requirement and a notice would need to be posted.	F 167	F 167 B. All residents families, visitors have the potential to be affected by failure to post a notice informing them that 3 preceding years survey results are available for review. C. The Nursing Directors or designee will perform ongoing monthly audits to ensure the notice is posted as required. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who-	F 225		

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F 225	Continued From page 2 (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 225	F 225 The facility shall ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, are reported immediately but no later than 2 hours after allegation is made of serious harm, or not later than 24 hours if the events of the allegation do not involve abuse and do not cause serious bodily. A. The administrator and nursing directors have been educated regarding need to make notifications per the abuse, neglect, and misappropriation of property policy. Education will be provide to all nursing staff at the staffing meeting and online education. B. All residents families, visitors have the potential to be affected by failure to report allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriate of property.	

7.24.17

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F 225	Continued From page 3 accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 staff interview, review of incident investigations, and review of policy and procedure, the facility failed to ensure reporting requirements were met for 1 of 2 incidents reviewed which required reporting to local agencies and the state survey agency. The findings were: Review of the 5/8/17 investigation showed there was a controlled medication diversion involving 5 residents' medications (#7, #11, #27, #71, #73). The facility identified opioid medications were being replaced with an anti-hypertensive medication that was similar in appearance. Review of the facility's investigation showed it was thorough and no outcome to the residents was identified. However, the facility failed to report the incident to local law enforcement, adult protective services, or the State Survey Agency. The incident involved alleged misappropriation of	F 225	F 225 C. The Nursing Directors or designee will perform ongoing monthly audits to ensure proper notifications are made in accordance with facility policy on abuse, neglect and misappropriation of property. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 225	Continued From page 4 resident medications and alleged neglect related to the administration of the wrong medication. Interview with the administrator on 6/22/17 at 9:37 AM revealed they had not reported the incident because at that time they were focused on the investigation and had not thought of it as a case of abuse, neglect, or misappropriation of resident property. Review of the facility policy and procedure titled "Abuse: Recognizing and Reporting 05/2017" showed the definition of abuse to include misappropriation of resident property, mistreatment and neglect. The policy further showed any case of suspected abuse of a vulnerable adult must be reported to the local police department, the State Survey Agency and adult protective services.	F 225		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure resident dignity related to dining was afforded to 1 of 15 sample residents (#16). The findings were: Review of the 5/23/17 MDS quarterly assessment showed resident #16 had moderate cognitive impairment, required extensive assistance with	F 241	F 241 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 dining experience. A. Resident #16 will be treated with respect and dignity and will be offered assistance per the plan of care, an alternate food choice will be offered if meal is not palatable or intake is less than 50%, and ensure the food is warm. The care plan will be updated to reflect this and reviewed by the nursing staff. B. All residents have the potential to be affected by failure to ensure that the resident's dignity is maintained and or enhanced during their dining experience.	

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F 241	Continued From page 5 mobility and required limited assistance with meals. S/he was totally dependent on staff for locomotion in his/her wheelchair. Diagnoses included dementia. Review of the care plan, revised on 3/2/17, showed staff were directed to position the resident at the nurses station for meals, and provide limited assistance, and the resident needed a calm quiet setting at meal times with adequate eating time. The following concerns were identified: a. Observation on 6/19/17 at 8:55 AM showed the resident sat in his/her wheelchair at a table in the nurse's station area with an uncovered breakfast tray positioned in front of him/her from 8:55 AM until it was removed at 10:15 AM (1 hour and 20 minutes). Continued observation revealed CNA #5 provided verbal encouragement at 9:35 AM and again at 9:45 AM. Throughout the observation additional assistance was not provided, staff did not offer to reheat the eggs, hot cereal, and ground meat on the resident's plate; nor did they offer food substitutes. The observed amount of food consumed by the resident was 25%. b. Interview with CNA #5 on 5/21/17 at 9:30 AM revealed routine care for this resident included allowing the resident to feed him/herself breakfast until 9 AM. The CNA also stated the resident ate better when staff did not sit with him/her, therefore, staff had been directed to assist by giving verbal cues. c. Interview with the DON #2 on 5/21/17 at 6:50 PM revealed the resident should not sit with cold food for prolonged periods of time without staff making efforts to get the resident to eat, either by making changes in the food, including the temperature if needed, or providing physical and verbal assistance.	F 241	F 241 Cont. C. All nursing staff will be educated regarding the need to maintain resident's dignity by providing assistance with meals per the plan of care, offering different choices if food is not palatable or intake is less than 50%, and making sure the residents food is kept warm or reheated if needed. The Nursing Director or designee will complete ongoing monthly audits to ensure that residents dignity related to dining was afforded. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 274 F 274 SS=D	Continued From page 6 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a significant change assessment was completed for 1 of 3 sample residents (#30) who had a significant change. The findings were: Review of the 1/17/17 annual MDS assessment showed resident #30 was independent for locomotion and eating, and required supervision for transfers, ambulation, and personal hygiene. Review of the 4/18/17 quarterly MDS assessment showed there was a decline in the resident's ADL functioning as well as a significant weight loss. The resident's weight was 83 pounds on the 1/17/17 MDS assessment, and 72 pounds on the 4/18/17 quarterly MDS assessment, a decrease of 13 percent in the 3 month period. The ADLs which had been independent and supervised were now shown to be limited assistance on the 4/18/17 quarterly MDS assessment. Interview with the MDS coordinator on 6/21/17 at 4:40 PM	F 274 F 274	F274 The facility completes within 14 days after facility determines, or should have determined a significant change comprehensive assessment. A. A significant change of condition (decline) will be completed for resident # 30. Education will be provided to the IDT team regarding criteria of significant change in condition and weekly meetings will be held to discuss upcoming MDS assessments with nursing staff. B. All residents have the potential to be affected by failure to complete a significant change in status assessment when resident has declined/improved. C. The MDS Coordinator or designee will perform audits to ensure significant change assessments are completed in accordance with guidelines. D. The MDS Coordinator or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 274	Continued From page 7 verified a significant change assessment was indicated.	F 274	F 309 The facility shall ensure effective documentation, monitoring, and re-assessment for residents requiring wound management A. 1. a. The lack of evaluation for effectiveness of interventions for resident #52 is a past event and cannot be corrected. 1.b. The lack of weekly wound documentation for resident #52 is a past event and cannot be corrected. 1.c. Wound Care Guidelines-Prevention of Pressure Ulcers and Skin Tears policy and procedure has been reviewed and updated. 1. d. A process will be implemented (Treatment Administration Record) to aid in the assessment, treatment, pain assessment and follow-up of wound documentation and effectiveness of treatments for all residents and will include resident #52. The wound care nurse or other qualified RN will collaborate with nursing staff that provide primary care to the residents. The wound care nurse or qualified RN will make follow-up visits as needed and make recommendations for further treatment as necessary. Photographs will be taken upon identification of wounds and the follow-up frequency will be determined by the wound care nurse or qualified RN.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and	F 309		

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F 309	Continued From page 8 preferences. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, staff interview and medical record review, the facility failed to ensure wound management included effective documentation, monitoring,and re-assessment for 2 of 5 sample residents (#7, #52) who required wound management. The findings were: 1. Review of the 3/28/17 significant change MDS showed resident #52 had severe cognitive impairment, and required extensive assistance with ADLs. This review also revealed diagnoses which included chronic kidney failure, diabetes, and chronic non-pressure wound on the left heel. Review of the care plan, revised 4/4/17, showed interventions for wound care included the following: Assess/monitor wound healing on the left heel, measure length, width and depth when possible; assess and document status of the wound perimeter, wound bed and healing progress and report improvements and declines to physicians. According to the 12/28/16 nurse progress notes there was a 1.3 centimeter (cm) x 1.5 cm area of eschar on the resident's left heel. Review of the most current assessment, dated 6/11/17, showed the left heel had a black circular area with a white scab center measuring 0.7 cm by 0.8 cm. Observation on 6/21/17 at 6:25 PM with DON #2 revealed the resident had a area of eschar on the left heel that measured approximately .07 cm x .08 cm. with surrounding red tissue. The following concerns were identified: a. Review of the January 2017 physician orders and treatment administration records (TAR) showed foam boots, bed cradle, A&D	F 309	F 309 2. a. The reevaluation of resident #7 7 days after the order dated 5-7-17 is a past event and cannot be corrected. 2.b.The lack of documentation for resident #7 on 5-31-17 is a past event and cannot be corrected. 2.c. A process will be implemented (Treatment Administration Record) to aid in the assessment, treatment, pain assessment and follow-up of wound documentation and effectiveness of treatments for all residents and will include resident #7. The wound care nurse or other qualified RN will collaborate with nursing staff that provide primary care to the residents. The wound care nurse or qualified RN will make follow-up visits as needed and make recommendations for further treatment as necessary. Photographs will be taken upon identification of wounds and the follow-up frequency will be determined by the wound care nurse or qualified RN. B. All residents with wounds have the potential to be affected by inconsistent wound management which includes effective documentation, monitoring, and reassessment.	

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F 309	Continued From page 9 ointment, and Mepilex (a soft and highly conformable foam dressing that absorbs exudate and maintains a moist wound environment) were prescribed for wound care, and at the time of the survey, 6/19/17 to 6/22/17, this had not changed with the exception of A&D ointment was discontinued on 6/14/17. In an interview on 6/21/17 at 6:40 PM, the wound nurse was unable to provide information regarding an evaluation of the effectiveness of the treatment and interventions that remained unchanged for the past 5 months. b. Review of the April 2017 to June 2017 weekly skin notes and nurse progress notes with the wound care nurse on 6/21/17 at 4:40 PM showed the wound on the left heel was not assessed 4/10/17 to 4/22/17, 5/14/17 to 5/28/17, and 6/12/17 to 6/21/17. Further review showed inconsistent documentation regarding pain, the date the wound was first identified, and interventions that were being implemented at the time of the assessment. During the review the wound care nurse stated the nurses had not followed the care plan and facility standards for wound care that required weekly skin assessments. She further stated inconsistent documentation of the status of wounds made it difficult to determine the effectiveness of the interventions. c. Review of "Wound Care Guidelines-Prevention of Pressure Ulcers and Skin Tears," effective date November 2004, revealed a requirement for taking weekly photographs of wounds and pressure ulcers; but requirements for monitoring, documentation, and periodic reassessments were not included in this wound management policy and procedure. 2. Review of the 5/30/17 quarterly MDS	F 309	C. All Nursing staff, including travelers, will be educated about new processes of wound documentation. Education will include completion of assessment, treatment, pain assessment and follow-up of wound documentation. D. The Nursing Directors or designee will perform ongoing weekly audits to ensure the weekly wound documentation is completed. E. The Nursing Directors or designee will aggregate the random weekly data and report results to the Resident Care Services Administrator monthly and to the Care Center Medical Director monthly and Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 309	Continued From page 10 assessment showed resident #7 required extensive assistance for transfers, bed mobility, and toileting. The resident had moderate cognitive impairment, was frequently incontinent of bladder, and was at risk for developing pressure wounds. Review of the list of residents with wounds provided on 6/19/17 showed the resident was being tracked related to a buttocks wound. Review of nursing notes dated 6/18/17 at 2:22 PM, 6/18/17 at 5:38 PM, and 6/21/17 at 12:23 PM showed the resident was treated for pain related to the buttocks, legs, and coccyx areas. Review of the June 2017 treatment administration record (TAR) showed there were no wound care orders. The following concerns were identified: a. Review of the May 2017 TAR showed the resident had an order dated 5/7/17 for wound care which included "solosite gel" and "mepilex" to the left and right buttocks for 7 days and then "re-evaluate." b. Review of the skin/wound notes showed the most recent assessment was dated 5/31/17. The note showed the resident had intact skin, and continued to have a "hyper growth" on the left buttock. Further, the note showed the skin on the right and left buttocks was dry and flaky. There were no measurements included. c. Observations of the wound with DON #2 on 5/21/17 at 6:25 PM showed an area of redness surrounded the reddened hyper growth on the left buttock. Further observation showed a quarter-sized skin-eroded red area below the hyper growth. d. Interview with DON #2 on 6/21/17 at 6:57 PM revealed the area required monitoring and treatment.	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		

7.24.17

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	535045	A. BUILDING _____ B. WING _____	C 06/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=E	Continued From page 11 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident interview, medical record review, review of staffing and bath schedules, and staff interview, the facility failed to ensure bathing was completed for 7 of 15 sample residents (#11, #13, #27, #31, #73, #74, #75) and 1 non sample resident (#33) who required assistance with bathing. The findings were: 1. Interview on 6/20/17 at 2:30 PM with a group of residents revealed they were concerned about not receiving showers/baths more than once per week. Of the 10 residents present, 5 had concerns because they were scheduled for bathing at least twice per week and were only getting bathed once per week due to a lack of staffing. The residents' statements included, "...been ongoing for a while" and "...worried I smell bad." 2. Interview with bath aide #1 on 6/22/17 at 9:31 AM verified the showers/baths were not always done as scheduled due to inadequate staffing. 3. Review of the May 2017 schedule assignment sheets showed the plan was for 1 bath aide per unit (North and South) for the day and night shifts. Review of the day shift showed there were 13 days when there was only 1 bath aide to cover both units. Review of the night shift showed there were 13 nights when there was only 1 bath aide to cover both units, 4 nights with 1 bath aide and	F 312	F312 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A. Each unit (north and south) will have a bath aid scheduled for the day and evening shifts every day in order to ensure residents are receiving baths and or showers per their choice and plan of care. Residents # 11, 13, 27, 31, 73, 74, 75, 33, and ALL residents will receive baths and or showers in accordance with their plan of care. B. All residents have the potential to be affected by failure to ensure assistance for bathing/showering in accordance with their choice/preference and care plan. C. The Nursing Directors or designee will perform weekly audits of ADL documentation for 1 month and then monthly to ensure residents are receiving baths/showers per plan of care. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date	08/6/2017

7.26.17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 12 a partial shift covered, and 2 nights with no bath aide coverage at all. 4. Review of the June 1-21, 2017 schedule assignment sheets showed the plan was for 1 bath aide per unit (North and South) for the day and night shifts. Review of the day shift showed there were 2 days without any bath aide, and 6 days with 1 bath aide to cover both units. Review of the night shift showed there were 7 nights with no bath aide, and 7 nights with 1 bath aide for both units. 5. Review of the 5/2/17 quarterly MDS assessment showed resident #75 required extensive assistance for personal hygiene and bathing. The resident was cognitive with a brief interview for mental status (BIMS) of 15/15. Review of the care plan showed the resident "requires assistance from one staff member to shower three times per week." Review of the electronic medical record (EMR) bathing documentation showed in the past 30 days, the resident received only 9 showers. These were provided on: 5/24, 5/26, 5/29 , 5/31, 6/5, 6/7, 6/12, 6/14, and 6/19. 6. Review of the bathing care plan initiated on 3/22/17 showed resident #74 "does need assistance with bathing twice weekly." Review of the quarterly MDS assessment dated 6/13/17 showed the resident was totally dependent with 2 person assist for bathing. Review of EMR bathing documentation for the previous 30 days showed the resident received baths on 5/31/17, 6/7/17, 6/12/17 and on 6/21/17. 7. Review of the bathing care plan revised on 4/5/17 showed resident #73 "requires assistance	F 312		

7.26.17

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F 312	Continued From page 13 from one to two staff member for bathing twice weekly." Review of the quarterly MDS assessment dated 3/28/17 showed the resident was totally dependent with 1 person assist for bathing. Review of the EMR bathing documentation for the previous 30 days showed the resident received baths on 5/31/17, 6/7/17, 6/14/17, and 6/21/17. 8. Review of the bathing care plan dated 4/28/17 showed resident #31 was "dependent upon staff for bathing twice weekly." Review of the quarterly MDS assessment dated 5/30/17 showed the resident required extensive assistance with 1 person assist for bathing. Review of the EMR bathing documentation for the previous 30 days showed the resident received baths on 5/23/17, 5/30/17, 6/8/17, and 6/13/17. There was one refusal documented on 5/25/17. 9. Review of the bathing care plan dated 4/7/17 showed resident #27 "takes an arjo bath twice weekly and dependent upon one staff." Review of the admission MDS assessment dated 4/9/17 showed the resident required extensive assistance with 2 person assist. Review of the EMR bathing documentation showed in the previous 30 days the resident received baths on 5/23/17, 5/30/17, 6/6/17, and 6/20/17. There was a refusal documented on 5/26/17. 10. Review of the bathing care plan dated 3/28/17 showed resident #13 required "assist of one staff twice weekly." Review of the quarterly MDS assessment dated 3/21/17 showed the resident required extensive assistance with 1 person assist. The resident was cognitive with a BIMS of 15/15. Review of the bathing documentation showed the resident received baths on 5/30/17,	F 312		

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F 312	Continued From page 14 6/6/17, and 6/13/17. 11. Review of the 3/28/17 MDS assessment showed resident #11 had moderate cognitive impairment, and required extensive assistance with personal hygiene and total assistance with bathing. Review of the care plan, last reviewed on 4/5/17, showed staff were to provide assistance with bathing once per week. Review of the EMR bathing documentation showed the resident did not receive a shower from 6/1/17 to 6/11/17. Interview with DON #1 on 5/21/17 at 10:50 AM, revealed the resident did not receive a shower because a bath aide was not scheduled on the evening shift on this patient's unit on two days during that time frame. 12. Review of the 5/9/17 quarterly MDS assessment showed resident #33 required supervision for personal hygiene and extensive assistance for bathing. The resident was cognitively intact with a BIMS of 15/15. Review of the bathing schedule provided on 6/21/17 showed the resident was on the day schedule for Tuesday, Thursday and Saturday. Review of the EMR bathing documentation showed in the previous 30 days, the resident received only 8 showers. These were provided on: 5/23, 5/30, 6/1, 6/3, 6/6, 6/8, 6/13, and 6/15. Interview with the resident on 6/22/17 at 9:10 AM revealed it had been 7 days since his/her last shower and s/he was not satisfied. 13. Interview with DON #1 on 6/22/17 at 8:28 PM verified when the baths and showers were not done as scheduled it was due to staff shortages.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 15 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure post-fall evaluations included sufficient information to identify effective fall reducing interventions for 1 of 6 sample residents (#11) who required post-fall evaluations. The finding were: 1. Review of the 3/28/17 quarterly MDS assessment showed resident #11 had moderate cognitive impairment, required extensive	F 323	F 323 The facility must ensure that the resident's environment remains as free from accident hazards as is possible. Based on observation, staff interview and medical record review, the facility failed to ensure post-fall evaluations included sufficient information to identify effective fall reducing interventions. A. Post fall assessment will be modified to include interventions that are in place and if the interventions that are place are effective. Education will be provided to nursing staff to include interventions in place prior to fall on post fall assessments and if they are effective. B. All residents' have the potential to be affected by not including fall interventions in place and if effective on post fall assessment. C. The Nursing Directors or designee will perform ongoing monthly audits to ensure interventions and effectiveness of the interventions in place are completed on the post fall assessment.	

4.26.17

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F 323	Continued From page 16 assistance with toileting, and limited assistance with transfers. Further review showed s/he used a wheelchair independently for mobility. Diagnoses included heart failure, history of a fractured hip, and pain. Review of the 12/27/16 significant change MDS and 3/28/17 quarterly MDS showed no falls or fractures occurred in the past 6 months or since the previous assessment. Review of the care plan, revised 4/4/17, showed the resident required extensive assistance with peri care and limited assistance with transfers. Further review revealed the resident "will at times transfer without assistance," and interventions for fall risk included the following: be sure call light is within reach and encourage the resident to use it for assistance as needed; needs prompt response to request for assistance; ensure wears non-skid footwear; needs floors free from spills and clutter, adequate light, working and reachable call light, bed in low position at night; hand rails on walls and personal items within reach. The following concerns were identified: a. Review of the post-fall assessments showed the resident had non-injury falls on 5/7/17, 5/18/17, and 5/26/17. Further review of the three post-fall assessments showed no assessment of the interventions to determine whether all were in place and functioned properly as directed by the care plan. This review revealed no information regarding the resident's ability to access the call light or whether there was staff delay in responding to an activated call light. b. Observation on 6/20/17 at 9:45 AM, revealed the resident wheeled him/herself to the bathroom and transferred to the commode without assistance. At that time the resident stated staff wanted him/her to use the call light but s/he did not activate the call light prior to going to the bathroom because "it takes too long	F 323	F 323 D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 323	Continued From page 17 for" staff to respond. c. Observation on 5/21/17 at 10:05 AM revealed the resident was positioned in his/her wheelchair and expressed the desire to go to the bathroom. The call light was observed to be in the wastebasket at the end of the bed. Further, the over-bed table was between the resident and the wastebasket; and the resident was unable to physically move the over-bed table and bend to retrieve the call light from the wastebasket. d. Interview with DON #1 on 5/21/17 at 10:50 AM revealed the resident had not fallen since June 2016 and in the month of May 2017 s/he fell 3 times (11 months later). The DON further stated staff had not done a review to determine what changes might have occurred to cause the resident to start falling.	F 323		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff.	F 353	F353 The facility must provide services by sufficient number of nursing personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. A. Each unit (north and south) will have a bath aid scheduled for the day and evening shifts every day in order to ensure residents are receiving baths and or showers per their choice and plan of care. Residents # 11, 13, 27, 31, 73, 74, 75, 33, and ALL residents will receive baths and or showers in accordance with their plan of care.	

7.26.17

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F 353	Continued From page 18 (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident interview, medical record review, staff interview, review of bathing schedules, and review of the staff schedule assignments, the facility failed to ensure sufficient nursing staff to provide bathing for 7 of 15 sample residents (#11, #13, #27, #31, #73, #74, #75) and 1 non sample residents (#33) who required assistance with bathing The findings were: 1. Interview on 6/20/17 at 2:30 PM with a group of	F 353	B. All residents have the potential to be affected by failure to ensure assistance for bathing/showering in accordance with their choice/preference and care plan. C. The Nursing Directors or designee will perform weekly audits of ADL documentation for 1 month and then monthly to ensure residents are receiving baths/showers per plan of care. D. The Nursing Directors or designee will aggregate the random monthly data and report results to the Resident Care Services Administrator and the Care Center Medical Director monthly and to Quality Council quarterly. Quality Council will have the overall responsibility to ensure the facility is in compliance. Completion Date 08/6/2017	

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F 353	Continued From page 19 residents revealed they were concerned about not receiving showers/baths more than once per week. Of the 10 residents present, 5 had concerns because they were scheduled for bathing at least twice per week and were only getting bathed once per week due to a lack of staffing. The residents' statements included, "...been ongoing for a while" and "...worried I smell bad." 2. Interview with bath aide #1 on 6/22/17 at 9:31 AM verified the showers/baths were not always done as scheduled due to inadequate staffing. 3. Review of the May 2017 staff schedule assignment sheets showed the plan was for 1 bath aide per unit (North and South) for the day and night shifts. Review of the day shift showed there were 13 days when there was 1 bath aide to cover both units. Review of the night shift showed there were 13 nights when there was 1 bath aide to cover both units, 4 nights with 1 bath aide and a partial shift covered, and 2 nights with no bath aide coverage at all. 4. Review of the June 1-21, 2017 staff schedule assignment sheets showed the plan was for 1 bath aide per unit (North and South) for the day and night shifts. Review of the day shift showed there were 2 days without any bath aide, and 6 days with 1 bath aide to cover both units. Review of the night shift showed there were 7 nights with no bath aide, and 7 nights with 1 bath aide for both units. 5. Review of the 5/2/17 quarterly MDS assessment showed resident #75 required extensive assistance for personal hygiene and bathing. The resident was cognitive with a brief	F 353		

7.26.17

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F 353	Continued From page 20 interview for mental status (BIMS) of 15/15. Review of the care plan showed the resident "requires assistance from one staff member to shower three times per week." Review of the electronic medical record (EMR) bathing documentation showed in the previous 30 days, the resident received only 9 showers. These were provided on: 5/24, 5/26, 5/29 , 5/31, 6/5, 6/7, 6/12, 6/14, and 6/19. 6. Review of the bathing care plan initiated on 3/22/17 showed resident #74 "does need assistance with bathing twice weekly." Review of the quarterly MDS assessment dated 6/13/17 showed the resident was totally dependent with 2 person assist for bathing. Review of EMR bathing documentation for the previous 30 days showed the resident received baths on 5/31/17, 6/7/17, 6/12/17 and on 6/21/17. 7. Review of the bathing care plan revised on 4/5/17 showed resident #73 "requires assistance from one to two staff member for bathing twice weekly." Review of the quarterly MDS assessment dated 3/28/17 showed the resident was totally dependent with 1 person assist for bathing. Review of the EMR bathing documentation for the previous 30 days showed the resident received baths on 5/31/17, 6/7/17, 6/14/17, and 6/21/17. 8. Review of the bathing care plan dated 4/28/17 showed resident #31 was "dependent upon staff for bathing twice weekly." Review of the quarterly MDS assessment dated 5/30/17 showed the resident required extensive assistance with 1 person assist for bathing. Review of the EMR bathing documentation for the previous 30 days showed the resident received baths on 5/23/17,	F 353		

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F 353	Continued From page 21 5/30/17, 6/8/17, and 6/13/17. There was one refusal documented on 5/25/17. 9. Review of the bathing care plan dated 4/7/17 showed resident #27 "takes an arjo bath twice weekly and dependent upon one staff." Review of the admission MDS assessment dated 4/9/17 showed the resident required extensive assistance with 2 person assist. Review of the EMR bathing documentation showed in the previous 30 days the resident received baths on 5/23/17, 5/30/17, 6/6/17, and 6/20/17. There was a refusal documented on 5/26/17. 10. Review of the bathing care plan dated 3/28/17 showed resident #13 required "assist of one staff twice weekly." Review of the quarterly MDS assessment dated 3/21/17 showed the resident required extensive assistance with 1 person assist. The resident was cognitive with a BIMS of 15/15. Review of the bathing documentation showed the resident received baths on 5/30/17, 6/6/17, and 6/13/17. 11. Review of the 3/28/17 MDS assessment showed resident #11 had moderate cognitive impairment, and required extensive assistance with personal hygiene and total assistance with bathing. Review of the care plan, last reviewed on 4/5/17, showed staff were to provide assistance with bathing once per week. Review of the EMR bathing documentation showed the resident did not receive a shower from 6/1/17 to 6/11/17. Interview with DON #1 on 5/21/17 at 10:50 AM, revealed the resident did not receive a shower because a bath aide was not scheduled on the evening shift on this patient's unit on two days during that time frame.	F 353		

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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 353	Continued From page 22 12. Review of the 5/9/17 quarterly MDS assessment showed resident #33 required supervision for personal hygiene and extensive assistance for bathing. The resident was cognitively intact with a BIMS of 15/15. Review of the bathing schedule provided on 6/21/17 showed the resident was on the day schedule for Tuesday, Thursday and Saturday. Review of the EMR bathing documentation showed in the previous 30 days, the resident received 8 showers. These were provided on: 5/23, 5/30, 6/1, 6/3, 6/6, 6/8, 6/13, and 6/15. Interview with the resident on 6/22/17 at 9:10 AM revealed it had been 7 days since his/her last shower and s/he was not satisfied. 13. Interview with DON #1 on 6/22/17 at 8:28 PM verified when the baths and showers were not done as scheduled it was due to staff shortages.	F 353		

7-26-17