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 05/15/2019

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 5/13/19 to 5/15/19. The survey was prompted by complaint intake WY000002829. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator NSA: Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and	F 600	1. All residents will be free from abuse,	6/26/19

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

Electronically Signed | 06/07/2019

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F 600	Continued From page 1 staff interview, review of facility investigations, and policy and procedure review, the facility failed to ensure residents were free from abuse or neglect for 2 of 4 residents (#2, #3) reviewed. This failure resulted in harm to resident #2, who sustained injuries that required transfer to the emergency room and stitches. The findings were: 1. Review of the medical record showed resident #2 was admitted to the facility on 9/12/17 with diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. Review of the quarterly MDS assessment dated 3/5/19 showed a brief interview for mental status (BIMS) score of 0 (indicating severe cognitive impairment), the resident required the extensive assistance of one staff member for transfers and dressing, did not ambulate, and was incontinent of bowel and bladder. The following concerns were identified: a. Review of nursing progress notes dated 4/18/19 showed the resident fell out of bed and sustained facial injuries which included a laceration to the ear. The resident was transferred to the emergency room and received stitches. b. Interview on 5/14/19 at 1:52 PM with CNA #3 revealed the CNA who cared for resident #3 on that day (CNA #1) asked for her help to transfer the resident from the bed, because the resident was wiggling and kicking his/her legs. She stated when they got to the resident's room, the resident was on the floor facing the wall. She stated she also noticed the bed was at a high level and the fall mat was not by the bed. She confirmed the bed should have been in the low position and the fall mat by the bed prior to getting help. She stated CNA #1 did not push the call light for help, because it was dinner time and	F 600	misappropriation of resident property, and exploitation. Staff will be reeducated about the different types of abuse and neglect and the required time frames for reporting to Administrator, Department of Health, State Board of Nursing, Law Enforcement, and Ombudsman. CNA staff members #1 and # 2 are no longer employed by the facility. 2.All residents have the ability to be affected by abuse and neglect and have the right to be free from abuse and neglect. 3.All staff will be reeducated about the different types of abuse and neglect and also the required time frames for reporting to Administrator, Department of Health, State Board of Nursing, Law Enforcement, and Ombudsman. The staff will view an online education session and the session will include a competency quiz. This education will be completed by all staff no later than June 05, 2019. Resident rights will be presented and reviewed by Social Service Worker during the monthly all staff meeting on June 12, 2019. Resident rights will then be included every 6 months after that. A mandatory all staff meeting on staff Compassion Fatigue will be conducted on June 26, 2019 and then yearly after that. 4.The Care Center Nursing Director or designee will perform monthly random audits and assessments to ensure residents are free from abuse and neglect. The assessments will include	

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F 600	Continued From page 2 it would have taken longer to get help because they were busy. c. Interview on 5/14/19 at 4:31 PM with the resident's roommate, who was cognitively intact, revealed s/he heard CNA #1 with the resident, and the resident was acting out by thrashing and kicking his/her feet out. The roommate stated the CNA left the resident and the next thing s/he heard was a thump. The roommate stated s/he pulled the curtain back and the resident was on the floor. The roommate further stated the bed was in a high position and the fall mat was not by the bed. d. Review of the resident's care plan showed a care area of Alzheimer's disease with interventions that included "bed in lowest position and wheels locked." Further review of the care plan showed the resident was at high risk for falls with interventions that included "Follow facility fall protocol." Review of the facility's High Risk Fall Interventions sheet showed, "bed low position, padded floor mat ...". e. Review of the Falls/Fall Risk Assessment revision date of 6/18 showed " ...If the patient/resident is determined to be at risk for falls, interventions will be initiated in the Nursing Care Plan. f. Interview with the DON on 5/14/19 at 4:14 PM revealed when he talked to CNA #1 about the incident on 5/6/19, she confirmed she left the bed in high position and did not put the fall mat by the bed. The CNA resigned from her position effective immediately at the conclusion of her 5/6/19 interview with the DON. g. An attempt to interview CNA #1 by phone was made on 5/14/19 at 1:15 PM, but there was no answer. 2. Medical record review showed resident #3 was	F 600	interviews of cognitively intact residents and head to toe assessments of cognitively impaired residents to confirm freedom from reports of concern of abuse and or emotional, psychological, or physical signs of abuse. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance. The Care Center Nursing Director or designee will conduct random monthly audits to ensure staff is following the resident plan of care and implementing interventions to ensure safety and freedom from harm and neglect. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	

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F 600	Continued From page 3	F 600		

admitted to the facility on 1/17/17 with diagnoses which included hypertension and macular degeneration. Review of the annual MDS assessment dated 1/15/19 showed the resident had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact, had impaired vision with corrective lenses, and required the extensive assistance of 1 staff member for toilet use. The following concerns were identified:

a. Interview on 5/13/19 at 4:00 PM with the NHA revealed the facility had investigated an incident that occurred on 5/7/19. He stated resident #3 alleged a CNA threw a call light at him/her.

b. Review of the facility's investigation showed the DON interviewed resident #3 on 5/8/19. The resident revealed CNA #2 "hollered something and threw my call light." Further review of the facility's investigation showed the resident was not injured.

c. Interview with the DON on 5/14/19 at 4:14 PM revealed CNA #4 had sent him an email on 5/11/19 at 12:45 AM about the incident. The email revealed a conversation the CNA had with NSA #1 about CNA #2. After receiving the email, the DON talked with NSA #1 on 5/11/19. The NSA told him CNA #2 told her she ripped the call light out of the resident's hand. The DON stated he called the police and placed CNA #2 on suspension pending the investigation.

d. Interview on 5/15/19 at 7:07 AM with NSA #1 revealed she worked on 5/7/19, the night of the incident. She stated the resident had nights where s/he would ring the call light constantly, and that night the resident held the call button down. The NSA further revealed CNA #2 came to her and was upset. CNA #2 told the NSA she ripped the call light out of the resident's hand, told

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F 600	Continued From page 4	F 600		

him/her to quit ringing it, and threw it at him/her. The NSA stated she did not report the incident because she did not think about it.

e. Interview on 5/15/19 at 7:10 AM with CNA #4 revealed she and NSA #1 went into the resident's room after the incident occurred. The resident was upset and told them to get out if they couldn't help. She stated the resident reported the incident to the nurse. She also stated she sent an email about the incident to the DON on 5/11/19, 4 days after the occurrence.

f. Interview on 5/14/19 at 7:30 AM with the resident revealed the resident did not recall the event and had no complaints about the facility.

g. Attempts to interview CNA #3, who was on suspension from the facility, by phone were made on 5/14/19 at 10:35 AM and 1 PM, and a message was left for a return call. The CNA did not return the phone call.

h. Interview with the NHA on 5/15/19 at 7:33 AM revealed the nurse did not conduct a skin assessment. He also stated his expectations when residents excessively used the call light were that staff would provide one to one care, redirect the resident, and have 2 staff care for the resident to help the resident. He also stated they would look at other issues that would cause the excessive call light use like an underlying illness, or pain. He stated staff were encouraged to confront staff who seemed frustrated, and find out what was going on. He stated staff were encouraged to change assignments if needed, and let that staff member take a break. He stated they had been working on strategies in the Nursing Practice Council to recognize and help with staff burnout. He stated they have free massages one day a week, and will do cook-outs. He stated they just had a training in January on harassment and employee conduct. He further

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F 600	Continued From page 5 stated they did not let staff who liked to work extra put in too many shifts. i. Interview on 5/14/19 at 4:14 PM with the chief operations officer revealed staff received abuse training through human resources upon hire and before resident contact. Abuse training was also provided annually. j. Review of the "Abuse: Recognizing and Reporting" policy revised 6/15 showed, "I. Any employee or member of the medical staff, who suspects, after assessment of the patient/resident, that the patient/resident may be a victim of abuse, will proceed according to policy and the laws established for reporting abuse ..."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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 accordance with State law through established procedures.	F 609		6/26/19

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F 609	Continued From page 6 §483.12(c)(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 medical record review, staff interview, review of State Survey Agency incident reporting date, and policy and procedure review, the facility failed to report allegations of abuse or neglect to the State Survey Agency in a timely manner for 2 of 2 allegations reviewed. The findings were: 1. Medical record review for resident #2 revealed s/he was admitted to the facility on 9/12/17 with diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. Review of the quarterly MDS assessment dated 3/5/19 showed the resident required the extensive assistance of 1 staff member for transfers and dressing. The following concerns were identified: a. Review of nursing progress notes dated 4/18/19 showed the resident fell out of bed, and sustained facial injuries including an ear laceration. The resident was transferred to the emergency room and received stiches to the ear. b. Interview with the NHA on 5/14/19 at 1:30 PM revealed he and the DON discussed their concerns about the resident's fall, and the facility started an investigation on 5/1/19. He further stated he thought the timeframe for reporting allegations of neglect was within 30 days. c. Interview with the DON on 5/14/19 at 4:14 PM revealed staff brought concerns regarding the incident to the NHA on 5/1/19. He stated he	F 609	1. The two (2) allegations of Abuse and Neglect that were filed untimely cannot be fixed due to fact they are already passed the required reporting time. 2. All residents have the ability to be affected by failure to report abuse, neglect, or misappropriation in a timely manner. 3.All staff will be reeducated about the different types of abuse and neglect and also the required time frames for reporting to Administrator, Department of Health, State Board of Nursing, Law Enforcement, and Ombudsman. The staff will view an online education session and the session will include a competency quiz. This education will be completed by all staff no later than June 05, 2019. Facility will update policy “Abuse recognizing and reporting” to include the proper time frame for reporting allegations of abuse and neglect to the State Survey Agency. 4.The Care Center Nursing Director or designee will monitor and conduct random monthly audits of any incidents reported to the Office of Healthcare Licensing and Surveys (OHLS) to ensure compliance	

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F 609	Continued From page 7 contacted the CNA involved on 5/2/19 and put her on suspension pending the results of the investigation. d. Review of State Survey Agency incident reporting data showed the incident was reported to the agency on 5/8/19 as an allegation of neglect, 20 days after the incident occurred and 7 days after the facility began an investigation. 2. Medical record review showed resident #3 was admitted to the facility on 1/17/17 with diagnoses that included hypertension and macular degeneration. Review of the annual MDS assessment dated 1/15/19 showed the resident had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. The following concerns were identified: a. Interview with the DON on 5/14/19 at 4:14 PM revealed he was investigating an allegation of abuse that occurred on 5/7/19. He stated during an interview with the resident on 5/8/19 the resident alleged a CNA threw a call light at him/her. The resident denied injury. The DON further stated he reported the allegation to the State Survey Agency on 5/12/19. b. Review of State Survey Agency incident reporting data showed the allegation was reported to the agency on 5/15/19, 8 days after the incident occurred. 3. Review of the facility policy "Abuse: recognizing and reporting" revised 6/15 failed to show the required timeframe for reporting allegations of abuse and neglect to the State Survey Agency.	F 609	with the reporting timeframe requirements. The audit data will be will aggregated monthly and reported to the Administrator, Medical Director, QAPI Steering Committee, and quarterly. The QAPI Steering Committee will ensure compliance.	