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 11/13/2019

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 complaint survey was conducted by Healthcare Licensing and Surveys on 11/13/19. The survey was prompted by complaint intake WY00002970. The following common abbreviations are used through this document: RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	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, facility investigation review, family and staff interviews, and review of facility incident reports, the facility failed to ensure residents were free from abuse for 1 of 4 sample residents (#1). The findings were:	F 600	F600 1. All residents will be free from abuse, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and a	12/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/06/2019

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F 600	Continued From page 1 1. Review of the care plan for resident #1, last revised on 3/27/18, showed the resident was admitted to the facility on 3/10/17 with diagnoses which included Alzheimer's disease. Further review showed a "focus" of "I wander the Heart Mountain/West unit, wander with disregard to safety when unsupervised, and often intruding on others privacy or into others rooms related to dementia". Interventions included "distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, I prefer playing piano, listening to music, social events with music and exercising" and "I will be verbally redirected if/when I wander into another resident's room. Behavioral charting should be completed when this occurs." Review of the quarterly minimum data set (MDS) assessment dated 10/29/19 for resident #3 showed the resident was unable to complete the brief interview for mental status and was severely cognitively impaired. Review of the care plan for resident #3, last revised on 8/13/19, showed the resident was admitted on 7/29/19 with diagnoses which included unspecified dementia without behavioral disturbance. Further review showed a focus of "The resident is physically aggressive (hitting, punching, and slapping) staff and residents related to anger, dementia and poor impulse control". Interventions included "When resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later." The following concerns were identified: a. Review of the "Facility Investigation of Incident Report" dated 11/5/19 at 3:31 PM showed "RN heard someone cry out and heard a	F 600	physical or chemical restraint not required to treat the resident's medical condition. Resident # 3 was put on hourly behavior monitoring. Resident #3's care plan has been updated to include more individualized interventions to assist with redirecting Resident #3. Resident #3 will be transferred to the Colorado Plains Geriatric Behavior Mental Health unit on 12/09/2019. Resident #1 injuries have been treated and healed. 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. The staff will also review what interventions we have in place for behaviors and also adjusting interventions to be individualized in the care plan. 4. The Care Center Nursing Director or designee will conduct a monthly meeting to review residents who are at risk for behaviors. The meeting will include: reviewing residents care plans, reviewing residents who are on hourly behavior monitoring, discussing and adjusting care plans of residents with behavior symptoms, reviewing care plans for appropriate individualized interventions, and reviewing and adjusting if necessary of residents who are on Psychotropic medications. Results from the meeting will be reported quarterly to the Administrator, Medical	

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F 600	Continued From page 2 thump, went to investigate and found [resident #1] on the floor. [Resident #1] was lying on the floor on right side in another resident's room with another resident [Resident #3] standing above [him/her] rubbing [his/her] hand acting remorseful. [Resident #1] had a bloody and swollen lip." Further review showed "[Resident #3] did not have any bruises to hands at the time of assessment on 11/3/19, but assessment on 11/4/19 revealed [his/her] right hand had a light bruised area between knuckles of pointer finger and middle finger with no other problems noted." Review of the facility incident report dated 11/4/19 showed the incident was believed to be an unwitnessed resident-to-resident altercation. b. Interview with RN #1 on 11/13/19 at 1:20 PM revealed she heard resident #1 fall and went immediately to resident #2's room. She revealed resident #3 had a history of hitting staff and residents, and had been involved in another resident to resident altercation on 10/15/19, however, no new interventions were put in place to document the resident's behavior after that event. c. Interview with RN #2 on 11/13/19 at 4:30 PM revealed resident #3 had always been a difficult resident and a recent assessment by a psychiatric specialist resulted in an increase in the resident's psychotropic medication. d. Interview with resident #1's representative on 11/13/19 at 2:33 PM revealed they were very pleased with the resident's care, stating, "There has been a couple incidents of falls and altercations with other residents, but nothing bad."	F 600	Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	