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

SEP 19 2005

PRINTED: 09/07/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	08/25/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	999 AVENUE G POWELL, WY 82435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies and procedures, the facility failed to assure staff appropriately documented a medication error for one (#36) of five residents observed during medication passes. In addition, staff failed to maintain sterile technique while inserting a urinary catheter into the bladder for one (#27) of two residents. The findings were: 1. Observation on 8/22/05 at 6:10 PM showed registered nurse (RN) #14 prepared Phenobarbital (anti-convulsant, barbiturate which must be counted and signed for each time it is given) 30 milligrams (mg) for resident # 36. The RN signed out the medication in the narcotic book at 6:10 PM and administered it to the resident at 6:15 PM. However, the RN signed the medication administration record (MAR) as giving the medication at the scheduled time of 4 PM. Reconciliation of the medication with the August 2005 recapitulation of orders showed Phenobarbital 30 mg was specifically ordered at 10 AM and 4 PM. During an interview on 8/23/05 at 9:05 AM, a charge nurse, RN #28, stated that RN #14 should have given that specific dose of Phenobarbital at 4 PM as medications ordered at specific times were to be given at those times. According to the "2003 Mosby's Nursing Drug Reference," the drug should be given "exactly as ordered."	F 281	**F281** The facility will develop policies and procedures to ensure that the services provided meet professional standards of quality. This will be accomplished by: A. Nursing Director will educate RN #14 regarding the Medication Administration Error Policy. A. Resident #27 is no longer at this facility. B. The facility acknowledges that all Residents have potential to be affected by the failure to follow professional standards. The Director of Resident Care Services or designee will provide training/education to improve the quality of professional standards. C. The Nursing Directors will provide on-going education regarding medication administration and the procedure for medication errors. C. The Bowel & Bladder Nurse in conjunction with the Infection Control Nurse will review available catheter supplies and develop a system of safe supplies according to Resident needs. Nursing staff will be in-serviced related to the products selected and the process involved to maintain sterile procedure related to products. D. The Nursing Director in conjunction with the Pharmacist will perform audits to determine that narcotics are given at scheduled times and medication error reports are as per policy. Aggregate data will be reported quarterly to the Medication Error Committee. + Quality Council. E. The Infection Control Nurse in conjunction with the Bowel & Bladder Nurse will observe random catheterization procedures performed by staff to evaluate sterile technique. Aggregate data will be reported quarterly to the Quality Council.	09/30/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9-16-05

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.

AH 0945 on 9/26/05 the POC was approved & changes made by Chari Brandon-Dow DON & Karen Womack, RN Health Surveyor.

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F 281	Continued From page 1 Interview with a nursing director, RN #40, on 8/24/05 at 3:45 PM confirmed the nurse should have written the actual time she gave the medication on the MAR, reported it to the next shift, and treated the incident as a medication error. Review of the 3/05 policy and procedure, "Medication Administration: Errors," medication errors "must be reported to the practitioner who ordered the medication and properly entered in the patient's/resident's medical record...notification...should not exceed a 24 hour period from discovery." Review of the medical record from 8/22/05 to 8/23/05 showed no documentation recording the timing error. 2. Observation on 8/23/05 at 9:55 AM showed licensed practical nurse (LPN) #10 opened and prepared the necessary items to catheterize resident #27. During the observation, the LPN stated the resident was allergic to Betadine so she would use alcohol as a cleansing agent. The LPN opened three packets of alcohol wipes and laid them out for use. However, after donning sterile gloves, the LPN picked up each packet with her dominate hand and transferred it to her non-dominate hand before removing the alcohol wipes, thus contaminating the sterile gloves. The LPN then completed the procedure using the contaminated gloves. When questioned after the procedure, the LPN identified the catheterization as a sterile procedure and verified her break in sterile technique. During an interview on 8/24/05 at 3:45 PM, a nursing director, employee #40, confirmed the facility's expectation that all catheterizations are performed as sterile procedures.	F 281	**F281 SEE PREVIOUS PAGE**	
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS	F 282		

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F 282	Continued From page 2 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assure staff followed the toileting care plan for one (#27) of nine residents who were incontinent. The findings were: Observation on 8/23/05 at 9:30 AM showed certified nurse aide (CNA) #35 assisted resident #27 into bed. The CNA did not take the resident to the bathroom or ask if he/she needed to use the toilet. According to the 8/16/05 annual Minimum Data Set assessment, the resident had severely impaired cognition and was incontinent of bowel and bladder. Review of the 8/11/05 individualized bowel and bladder plan showed staff were to take the resident to the bathroom at 3 AM, 7 AM, 9 AM, 11 AM, 3 PM, 5 PM, and 7 PM. According to the 8/19/05 care plan, staff were to follow the individualized bowel and bladder plan. Interview with CNA #35 on 8/24/05 at 10:22 AM revealed she toileted the resident in the morning around 7 AM but not at 9 AM or 11 AM. The CNA stated she did not follow the care plan or the individualized bowel and bladder plan. Interview with the bowel and bladder coordinator (employee #18) on 8/24/05 at 10:40 AM confirmed the 8/11/05 bowel and bladder plan was current and staff were to toilet the resident at the specified times. The coordinator further stated	F 282	**F282** The facility will develop policy and procedure to ensure that qualified person(s) develop written care plans to proved and/or arrange services to Residents. This will be accomplished by: A. CNA #35 will be counseled regarding the importance of following the established care plan. B. The facility acknowledges that all Residents could be affected by staff not following individualized written care plans. C. All Nursing staff will be in-serviced regarding the care planning process as well as the importance of following the individualized care plans and the procedure to notify interdisciplinary team members of Resident condition changes. D. The Bowel & Bladder Nurse will perform random observations of compliance with established individualized toileting plans. Aggregate data will be reported to Quality Council.	**09/30/05**

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F 282	Continued From page 3 she was unaware staff were not following the plan.	F 282	**F282 SEE PREVIOUS PAGE**	