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 11/14/2023

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 from 11/13/23 through 11/14/23.The survey was prompted by complaint intakes WY00003628, WY0000364, and WY00003711. The following common abbreviations are used throughout this document: BIMS: Brief Interview for Mental Status MDS: Minimum Data Set 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 observation, medical record review, staff interview, facility incident report review, and facility policy review, the facility failed to protect	F 600	The facility will ensure that resident #7 will be protected from abuse, neglect, misappropriation of resident property, and	1/5/24

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

Electronically Signed | 12/08/2023

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F 600	Continued From page 1 the resident's right to be free from physical and mental abuse by residents for 1 of 3 sample residents (#7) reviewed for abuse allegations. The findings were: 1. Review of the admission MDS assessment dated 5/4/23 showed resident #7 had a BIMS score of 4 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, and depression. The following concerns were identified related to one incident of abuse: a. Review of the facility incident report dated 10/25/23 and timed 6:40 PM showed resident #5 had removed a "puppy" from the room of resident #7. When the stuffed animal was returned to resident #7 in his/her room, resident #5 returned to the room and staff found resident #5 with his/her hands around resident #7's throat and coffee had been spilled on resident #7. Further review showed the residents were separated and neither had noted injuries. b. Review of the nursing progress note for resident #7 dated 10/25/23 and timed 7:08 PM showed resident #7 was sitting in a recliner when resident #5 came up to [him/her] and placed his/her hands on resident #7's throat. The note indicated resident #7 screamed for help and no physical injury was noted; however, resident #7 continued to be "shaken" by the incident. c. Review of the nursing progress note for resident #5 dated 10/25/23 and timed 7:13 PM showed resident #5 had entered resident #7's room and removed a stuffed puppy. The puppy was carried into the common area where resident #7 observed resident #5 with the puppy and asked for it. The puppy was retrieved and given to resident #7; however, 10 minutes later resident	F 600	exploitation by taking the floowing immediate actions. 1. Within 24 hours insure that resident #5 has an item that will replace the item she is fixated on, in this instance a stuffed dog. 2. Increased supervision by staff of resident #7 and #5 to monitor for increased agitation. 3. Update the resident care plan with the interdisciplinary team to determine tactics to mitigate resident wandering and resident altercations. 4. Continue to move forward with acute admission to a geriatric psychiatric unit for appropriate medication changes for resident #7. This has been in process waiting for bed availability in Billings, MT. 5. Continue with regular visitation by PMHNP for resident #5 for continued evaluation of her reactions to other residents. All residents have the potential to be affected by these actions specifically in the secure dementia care unit secondary to the nature of their diagnoses and increased risk of wandering and decreased impulse control. The facility will take action to assure that all other residents will be protected from abuse, neglect, misappropriation of resident property, and exploitation throught the following changes: 1.The Interdisciplinary Team will review the care plans of those residents identified who exhibit tendencies to wander into other's rooms and assure that care plans have been updated with resident specific	

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F 600	Continued From page 2 #7 yelled s/he was being choked and needed help. Staff found resident #5 with his/her left hand on resident #7's throat, right hand grabbing resident #7's left wrist, and screaming at resident #7. After releasing resident #7, it was noted the resident's throat was red. 2. Interview with nurse #2 on 11/14/23 at 2 PM confirmed resident #5 wandered which resulted in resident to resident altercations at times and the residents in the secure unit had their favorite stuffed animal or blanket which can cause negative interactions. 3. Interview with the facility administrator on 11/14/23 at 4:15 PM confirmed the altercation occurred and revealed it seemed much worse at the time of occurrence than it really was. Further interview revealed neither resident remembered the incident two hours later. 4. Review of the facility policy and procedure titled "Abuse: Recognizing and Reporting" dated 3/2023 showed "...Abuse is identified as physical abuse, sexual abuse, mistreatment, neglect, or misappropriation of patient/resident property...VULNERABLE ADULT ABUSE...I. Inspect injured vulnerable adult patient's/resident's body upon admission and throughout the course of care for evidence of physical and/or sexual abuse, for unexplained signs and symptoms that might include bruises, welts, abrasions, contusions, lacerations, punctures, burns, scalding, bone fractures, sprains, dislocations, subdural hemorrhage, retinal hemorrhage, brain damage, internal injuries, poisoning, malnutrition (deliberately intended), freezing, or exposure. II. Describe, on the medical record, all unexplained bruises,	F 600	targeted nonpharmacological interventions to decrease altercations with others. 2. The Interdisciplinary Team will continue to evaluate risks for potential conflicts and pre-emptively put measures in place to decrease altercations. 3. Continue the pre-admission assessment of residents to evaluate appropriateness for the setting and potential for risk to other residents. System Measure to assure that deficient practice will not occur: 1. Education provided to all staff by completion date listed related to the care plans and targeted, resident specific interventions to decrease behaviors. 2. Review of the non violent crisis intervention education provided to staff previously to decrease escalation of behaviors and early intervention. 3. Focus in daily huddle to discuss potential conflicts and immediate review of the care plans to adjust as needed. 4. Initiate use of a debriefing tool (ie RCA) with the addition of floor staff after an allegation of abuse to more clearly define appropriate interventions and mitigate future occurrences. Performance Improvement Project will be initiated with auditing of information above with monthly collection of data, quarterly reporting to QAPI, and subsequently Quality Council.	

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F 600	Continued From page 3 lacerations, etc., as to location and state of healing..."	F 600		