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 _____	01/31/2025

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 1/28/25 through 1/31/25. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MDS: Minimum Data Set ADL: Activities of Daily Living Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		3/24/25

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

Electronically Signed | 02/19/2025

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.

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 _____	01/31/2025

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 676	Continued From page 1 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents received services to maintain or improve their ability to carry out activities of daily living for 1 of 3 residents (#21) reviewed for activities of daily living. The findings were: 1. Review of the quarterly MDS assessment dated 11/5/24 showed resident #21 had short-term and long-term memory problems and diagnoses which included Alzheimer's disease. The review showed the resident required substantial/maximal assistance with oral hygiene, toileting hygiene, upper and lower body dressing, rolling left and right, sitting to standing, sitting to lying, lying to sitting, and transfers. Further review showed during the look-back period the resident had 2 or more falls with no injury, a fall with minor injury, and did not receive therapy services or restorative nursing programs. Review of the "ADL self-care performance deficit" care plan last revised on 11/26/24 showed "...restorative staff to	F 676	1) Resident #21 immediately had her care plan reviewed and updated to ensure that the restorative program was accurate and reflective of appropriate needs. Education of the Restorative nurse and aides completed immediately regarding the documentation requirements, the Tag 0676, and care plan adjustment. 2) All residents have the potential to be affected by not having and following appropriate restorative plans to maximize their ability to maintain their current level of function and involvement in ADLs. The IDT will evaluate all care plans to ensure appropriate resident-centered restorative plans and interventions are in place for those requiring restorative plans. Mandatory education will be provided to all staff related to the importance of the restorative plans and their place in the quality of life in residents. The review of care plans and education to be completed	

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 _____	01/31/2025

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 676	Continued From page 2 encourage and assist me with walking. Weather and behaviors permitting I would like to go outside. Three times a week as tolerated..." The following concerns were identified: a. Review of the resident's record from 1/1/25 to 1/30/25 showed a restorative task for active range of motion and a program for ambulation two to three times per week. Further review showed no evidence the ambulation program was performed, offered, or refused and the active range of motion was only performed once, on 1/22/25, during the 30-day period. b. Interview with the restorative nurse on 1/31/25 at 8:37 AM revealed restorative CNAs should offer restorative programs 2 to 3 times per week and should document refusals. The restorative nurse revealed she "tries" to evaluate programs quarterly with the MDS assessments and she may have forgotten to change the resident's program to as needed. Further interview revealed sometimes restorative aides got pulled to work the floor if there was an opening; however, that was not an issue during the last 30 days. 2. Review of the policy titled "Restorative Program" dated 2/2024 showed "...Maintenance and restorative programs will be provided to residents as indicated by the resident's comprehensive assessment: I. To ensure the resident receives the care and services because he/she is unable to perform Activities of Daily Living, (ADL) independently. II. To promote resident wellness and maintenance or restoration of ADL functions..."	F 676	by completion date. 3) A plan has been developed with restorative staff to provide more consistent availability of the restorative room as well as a more rigid schedule for restorative aides to complete the restorative plan. In addition, there is a plan to use more of the floor staff to assist in achieving the goals for residents on their restorative plan. A Performance Improvement Plan will also be put in place to monitor the restorative plans and implement interventions as appropriate. 4) Random audits of the restorative plans will be conducted monthly by IDT to evaluate compliance with the care plans and restorative plans. Quarterly reporting of those audits will be reported to QAPI and Quality Council. Audits will start March 1, 2025.	