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 _____	06/14/2018

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POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/11/18 to 6/14/18. 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 RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		

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

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.

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F 585	Continued From page 1 accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 585		

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F 585	Continued From page 2 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, and resident interview	F 585		

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F 585	Continued From page 3 and staff interview, the facility failed to ensure residents were informed of the process for filing a grievance. In addition, the facility failed to identify a grievance official. The facility census was 83. The findings were: Observations during the survey dates of 6/11/18 to 6/14/18 showed no evidence of a posted grievance process. Interview on 6/12/18 at 2 PM with 10 cognitive residents (#3, #25, #39, #45, #48, #51, #52, #73, #75) showed they were unaware of how to file a grievance, and could not recall ever having been told how to use the grievance process. In addition, they were unaware if the facility had a staff member designated as the grievance official. Interview on 6/12/18 at 2:50 PM with the administrator and DON confirmed the facility had not appointed grievance official, and the grievance process was not posted. They stated grievance information was provided upon admission in an admission pamphlet.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		

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F 604	Continued From page 4 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to assess 1 of 1 sample resident (#15) with a potential restraint. The findings were: Review of the 9/12/17 annual MDS assessment showed resident #15 was rarely understood, aphasic, and a brief interview for mental status could not be completed. The following concerns were identified: a. Observations on 6/11/18 at 2:40 PM and 6/13/18 at 2:26 PM showed the resident had a padded mitten covering his/her right hand. b. Review of a 9/14/17 note timed 2:34 PM showed, "[The resident] is to wear a padded mitt to [his/her] right hand d/t [due to] [s/he] bites it and will break [his/her] skin open." c. Review of the resident's care plan showed: "I self injure myself by biting my hands r/t [related to] severe intellectual disability, overstimulation,	F 604		

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F 604	Continued From page 5 and self-stimulating behaviors. I am at risk for injury to my hands. I will wear my protective mitt on my right hand through the review date (target date 6/11/18). I wear padded mitts on my hands to prevent injury from biting." d. Review of the entire medical record showed no assessment to determine if the mitten was a restraint, and the least restrictive effective intervention. e. Interview with RN #1 on 6/13/18 at 2:26 PM confirmed the facility failed to ensure an assessment was completed to determine if the mitten was a restraint, and if the mitten was the least restrictive intervention that was effective. Interview with the DON on 6/13/18 at 3 PM confirmed the facility failed to assess the resident regarding use of the mitten.	F 604		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		

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F 623	Continued From page 6 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State	F 623		

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F 623	Continued From page 7 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the notice of	F 623		

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F 623	Continued From page 8 transfer was provided for 1 of 1 sample resident (#29) who was transferred to the hospital. The findings were: Review of the medical record showed resident #29 was transferred to the hospital on 3/4/18 and on 4/29/18 due to changes in condition. The review failed to show evidence a notice of transfer was provided to the resident or the resident's representative. Interview with the DON and the social service director on 6/14/18 at 9:23 AM revealed the facility was not aware of the required elements of the notice and did not have a process to ensure transfer notices were issued to the residents or responsible party upon transfer.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

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F 657	Continued From page 9 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to update the care plan for 1 of 18 sample residents (#15). The findings were: Observations on 6/11/18 at 2:40 PM and 6/13/18 at 2:26 PM showed resident #15 had a padded mitten covering his/her right hand. Review of a note dated 9/14/17 and timed 2:34 PM showed: "[S/he] is to wear a padded mitt to [his/her] right hand d/t [due to] [s/he] bites it and will break [his/her] skin open." Review of the care plan showed, "I self injure myself by biting my hands r/t [related to] severe intellectual disability, overstimulation, and self-stimulating behaviors. I am at risk for injury to my hands. I will wear my protective mitt on my right hand through the review date (target date 6/11/18). I wear padded mitts on my hands to prevent injury from biting." The following concerns were identified: a. Further care plan review revealed the plan lacked specifics as to when the mitten would be applied or removed, and if any less restrictive interventions would be attempted. b. Interview with the DON on 6/13/18 at 3 PM confirmed the facility failed to update the care plan to address these issues.	F 657		
F 745	Provision of Medically Related Social Service	F 745		

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F 745 SS=D	Continued From page 10 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure medically related social service needs were assessed and planned for 1 of 1 sample residents (#36) who required these services. The findings were: Review of the medical record showed resident #36 had diagnoses that included dementia. Review of the 3/27/18 quarterly MDS assessment showed the resident had some refusals of care behaviors; however, there was no behavior related to wandering or elopement. Review of the 5/29/18 nurse's note showed the resident was notified this day their spouse had died after being transferred to a hospital out of state. The resident and his/her spouse had shared a room at the facility prior to the hospitalization. Observation on 6/11/18 at 11:25 AM showed staff were visiting with the resident after bringing him/her back into the facility. The resident had gone outside without the staff's knowledge. Review of the incident report dated 6/11/18 showed the resident had been found outside the facility at 10 AM and again at 11:30 AM. The resident stated s/he was "going home and looking for [his/her] truck." The following concerns were identified: a. Review of the medical record failed to show any assessment related to grief and psycho-social needs after the resident's spouse died.	F 745		

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F 745	Continued From page 11 b. Review of the care plan showed there were no updates related to the death of the resident's spouse/roommate. The revised 4/3/18 care plan for activity participation showed the resident enjoyed sharing a room and spending time with his/her spouse. c. Interview with the social services director on 6/14/18 at 9:31 AM revealed an assessment had not been completed related to grief and loss, and the care plan would require updating.	F 745		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 803		

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F 803	Continued From page 12 personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of diet cards, review of the menu, and staff interview, the facility failed to ensure the menu was followed for 1 of 3 residents (#4) reviewed for accuracy of the meal. In addition, the facility failed to ensure diet orders were available and referenced when serving meals in the secure unit. The census of the unit was 14. The findings were: 1. Observation on 6/13/18 at 11:50 AM showed resident #4 was served a small portion of chicken strips and onion rings. These items were cut in to bite size pieces by the server. Interview at that time with the server, CNA #1 revealed the resident received small portions. She also verified no diet cards were used; she knew the residents and what they should receive. The following concerns were identified: a. Review of the diet card provided by the registered dietitian (RD) showed the resident had a regular diet with a mechanical soft texture and ground meat. There was no indication on the diet card the resident was to receive small portions. b. Review of the 6/13/18 noon menu showed the mechanical texture diet called for ground chicken and mashed potatoes and gravy in place of onion rings. c. Interview with the RD on 6/13/18 at 12 PM confirmed the staff serving the meals should follow the diet orders and resident preferences on the cards. She further verified the resident should have been served ground chicken rather than just cut pieces of chicken, and mashed potatoes and gravy in place of the cut up onion rings. 2. Observation on 6/13/18 at 11:39 AM showed	F 803		

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F 803	Continued From page 13 food was delivered to the secure unit. The food was received cooked and ready to serve in pans. The CNA/Server then portioned the food onto individual plates for the residents in the unit. The census of the unit was 14. The following concerns were identified: a. CNA #1 failed to reference any menu, or diet cards while preparing the residents' plates of food. b. Review of the information available in the unit kitchen showed there was some information on likes and dislikes; however, there were no diet orders available. c. Interview with the RD on 6/13/18 at 12 PM verified unless a resident made a specific request or refusal, the diet orders, planned menu for each diet, and resident preferences, were expected to be followed.	F 803		
F 811 SS=E	Feeding Asst/Training/Supervision/Resident CFR(s): 483.60(h)(1)-(3) §483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if- (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and (ii) The use of feeding assistants is consistent with State law. §483.60(h)(2) Supervision. (i) A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). (ii) In an emergency, a feeding assistant must call a supervisory nurse for help.	F 811		

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	535045	A. BUILDING _____ B. WING _____	06/14/2018

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F 811	Continued From page 14 §483.60(h)(3) Resident selection criteria. (i) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems. (ii) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. (iii) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan. This REQUIREMENT is not met as evidenced by: Based on review of program information, and staff interview, the facility failed to ensure residents requiring assistance with feeding were appropriate for the feeding assistant program. The census of residents requiring feeding assistance was 18. The findings were: Review of the program information showed a "Nutrition Support Assistant Program" was started in February of 2016. The facility had 6 employees who had successfully completed the program requirements and assisted residents with eating. The following concerns were identified: a. Interview with the DON on 6/13/18 at 10:50 AM verified there was no documentation to show which residents were selected to be included for the program. The DON stated she was unaware of the requirement to ensure, based on assessment, the residents being assisted were appropriate for the program. b. Review of a resident list provided by the facility RD on 6/13/18 showed 18 residents who required some level of feeding assistance/supervision.	F 811		

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F 811	Continued From page 15 c. Interview with the RD on 6/13/18 at 3 PM revealed there were several residents on the list who may not have been appropriate for the program related to complicated feeding problems.	F 811		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure proper use of expiration dates, gloves, and hair restraints in 2 of 4 kitchens (north unit kitchen, secure unit kitchen). The findings were: 1. Observation on 6/12/18 at 10:27 AM showed 8 cartons of thawed health shakes in the north unit kitchen refrigerator. These cartons were not labeled with any date to show when they were to	F 812		

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F 812	Continued From page 16 be discarded. Information on the label showed they were to be discarded within 14 days after being thawed. Observation on 6/13/18 at 10:38 AM showed 8 un-dated health shakes remained in this refrigerator. Interview with the certified dietary manager on 6/13/18 at 3:10 PM verified the shakes were expected to be individually dated with an expiration or discard date. 2. Observation on 6/13/18 at 11:39 AM showed food was delivered to the secure unit. CNAs #1 and #2 worked together to dish the food onto plates for the residents. The aides both wore disposable gloves and both aides on separate occasions during the serving process failed to remove the gloves when they became contaminated by handling the refrigerator door. In addition, both aides failed to wear hair restraints while preparing and serving the food to the residents. 3. According to Food Code 2017, U.S. Public Health Service: 2-402.11 "(A) ...FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." 4. According to Food Code 2017, U.S. Public Health Service: 3-501.17 Ready to Eat. Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking (B) Except as specified in (D)-(F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE	F 812		

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F 812	Continued From page 17 CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and : (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be Day 1. 5. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;	F 812		

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F 812	Continued From page 18 (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		