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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 .

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.

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