DEPARTMENT OF HEALTH AND HUM. .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/06/2006
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
	53A050	A. BUILDING _____ B. WING _____	02/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	110 HOSPITAL LN AFTON, WY 83110

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interviews, the facility failed to ensure three resident rooms and a common room were maintained in a comfortable, homelike manner. The findings were: a. Observations in resident room 218 on 2/21/06 at 4:25 PM, and 2/22/06 at 11 AM revealed a cabinet with a missing piece of laminate, approximately 3 x 4 our inches, at the base of the cabinet. In addition, there was a hole in the wall located behind the bed that was approximately 8 x 2 1/2 inches in size. Interview with resident #18 on 2/21/06 at 4:25 PM revealed the gouge on the closet had been there since s/he moved into the facility approximately 1 1/2 years before. The resident stated s/he had asked to have it fixed several times because it bothered him/her. The resident stated facility staff checked on it, but never fixed it. b. Observation in resident # 21's room on 2/22/06 at 9:30 AM and again at 11 AM revealed a 4 x 3 inch gouged and damaged area on the wall at the foot of the bed. Additionally, there was a 34 1/2 x 13 inch area on the wall near the side of the bed that was gouged and had chipped paint. Interview with resident #21 on 2/22/06 at 9:30 AM revealed the damaged areas on the walls of his/her room were bothersome. The resident further stated s/he did not know how long the chips and gouges were present, but that it	F 253	(a) 1. The cabinet has been painted 2. The hole in the wall will be repaired by maintenance. Interview with the resident indicated he is satisfied with the cabinet repair (painting). A different trapeze will be used to lessen damage to the wall. (b) The walls in resident #21's room will be repaired by maintenance	4/03/06 4/03/06

Facility will ensure a signed copy is faxed in the mail

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.

MAR 16 2006

The POC was approved & changes made on 3/20/06 @ 1545 by: Michelle Oliver, RN, DON, and Karen Wommack, RN, Health Services Manager

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PFAP11 Facility ID: WY00000 If continuation sheet Page 1 of 12

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F 253	Continued From page 1 had been "quite a long time." c. Observation on 2/22/06 at 7:25 AM in the bathroom of room #210 revealed there were four areas where the paint was scratched off on the wall across from the toilet. The areas measured 10 x 4 inches, 2 x 17 inches, 2 x 17 inches, and 2 x 3 inches. In addition, on the adjacent wall, there was a scratch which measured 2 x 3 inches. d. Observation on 2/21/06 at 4:05 PM in the common room revealed the wall next to the piano had a 10 foot long damaged area of chipped paint and gouges where chairs were being pushed up against the wall. Additionally, there was a four foot long section of chipped paint and numerous gouges where chairs were pushed up against the adjacent wall. e. Interview with the maintenance director on 2/22/06 at 11 AM confirmed he had been aware of the wall damage for six months. He also stated that he had been aware of the hole in room #218 for about one month.	F 253	(c) The walls in bathroom #210 will be repaired by maintenance.	4/03/06
			(d) In the commons room, the damaged wall will be repaired by maintenance. New chairs are being replaced per capital equipment and approval by administration	4/03/06
			(e) The condition of the facility's walls, as well as (a, b, c, and d) will be monitored monthly by the safety committee. Maintenance requests will be completed on the walls in need of repair. Requests versus repairs will be monitored in the QI committee meetings. D.O.N. will provide oversight.	4/03/06
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272	(f) All staff will be inserviced regarding the need to fill out maintenance slips.	

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F 272	Continued From page 2 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide comprehensive assessments of all identified problem areas for seven of ten sample residents (#2, #6, #10, #13, #18, #21, #22). The findings were: 1. Review of a 12/12/05 physician's progress note for resident #2 revealed "...insomnia a major problem." Review of current physician's orders revealed the resident received Ambien CR (sedative-hypnotic) 12.5 milligrams (mg) every night at bedtime for insomnia, and Melatonin (herbal supplement used for insomnia) 3 mg, 2 tablets, as needed at bedtime for insomnia. Review of the February 2006 medication administration record (MAR) revealed the resident received Ambien CR 12.5 mg on 2/7/06, 2/8/06 and 2/9/06. The resident received Melatonin 3 mg, 2 tablets, on 2/10/06, 2/11/06, 2/13/05,	F 272	For resident #2 and 1. The facility will use a comprehensive sleep assessment on all residents prior to being started on a sedative-hypnotic or melatonin or an assessment will be completed upon admission if the resident has a doctor's order at that time. The assessment will be completed and monitored by social services. Use of hypnotics and melatonin will be monitored monthly by pharmacist, social services, and administration, and D.O.N. Please see the attached assessment tool.	4/03/06 Currently taking and

For Resident # Slips 2 10 21 13 of 6
Record 21, 22 34 Slips

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F 272	Continued From page 3 2/14/06, 2/15/06, 2/17/06, 2/18/06, 2/19/06, 2/20/06, 2/21/06, and 2/22/06. During an interview on 2/22/06 at 4 PM, the director of nursing (DON) stated the resident had always had a problem with insomnia. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. During an interview on 2/22/06 at 4:10 PM, the DON stated there was no comprehensive assessment to determine reasons for insomnia, nor documentation of non-pharmacological interventions. 2. Review of the admission face sheet revealed resident #10 had a diagnosis of insomnia. Review of current physician's orders revealed the resident received Melatonin 3 mg at bedtime for insomnia. Review of the January and February 2006 MARs revealed the resident received Melatonin 3 mg everyday at bedtime. Review of the medical record revealed no evidence a comprehensive sleep assessment was completed to determine the resident's usual sleep pattern/disturbance and possible reasons for insomnia such as noise, pain, side effects of medication, stress, etc. During an interview on 2/22/06 at 4:10 PM, the DON stated there was no comprehensive assessment to determine reasons for insomnia, nor documentation of any attempts of non-pharmacological interventions. 3. Review of the annual 2/11/05, the 11/8/05 quarterly, and the 2/8/06 annual Minimum Data Set (MDS) assessments for resident #21 revealed s/he was incontinent of bowel all (or almost all) of the time. Review of the medical	F 272	The assessment tool and its use will be reviewed by Social Services every 6 months. Nurses will be in-serviced on proper procedures prior to ordering hypnotics or melatonin. This will be added to the facility QI plan. The resident needs after the assessment will be care planned. The D.O.N. will monitor this. ~~Actions~~ for Resident #10 2. The facility will use a comprehensive sleep assessment on all residents prior to being started on a sedative-hypnotic or melatonin. See attached assessment tool. The D.O.N. will monitor with charge nurses. Discussion will occur at monthly chemical review meetings. The assessment tool and its use will be reviewed by Social Services every 6 months. This will be added to the facility QI plan. The resident needs after the assessment will be care planned. The D.O.N. will monitor this. for resident #21 3. The bowel assessment was completed by restorative nurse and reviewed by clinical review committee. The D.O.N. will monitor the assessments. This will be included in the facility QI plan. All residents with Incontinence will be reviewed for Bowel Assessment.	4-03-06 4/03/06 3-14-06

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F 272	Continued From page 4 record revealed there was no bowel assessment completed for the resident. Interview with the director of nursing (DON) on 2/23/06 at 9:10 AM confirmed no bowel assessment had been done. In addition, review of the 2/06 physician's orders revealed the resident had orders for Ambien 5 milligrams (mg) as needed for insomnia. Review of the medical record revealed the resident had a sleep monitor completed in 2003, however, the monitor did not assess the reasons for insomnia. Medical record review also revealed no non-pharmacological alternatives were attempted. Interview with the DON on 2/22/06 at 4 PM confirmed no assessment of the resident's insomnia was completed and no non-pharmacological alternatives were attempted. 4. Review of the annual 9/27/05 MDS assessment for resident #22 revealed s/he was frequently (2-3 times per week) incontinent of bowel. Review of the 12/28/05 quarterly MDS assessment revealed the resident was incontinent all (or almost all) of the time. However, review of the medical record revealed there was no bowel assessment completed for the resident. Interview with the DON on 2/23/06 at 9:10 AM confirmed no bowel assessment had been done. 5. Review of the 2/06 physician's orders for resident #13 revealed s/he had orders for Lunesta (a sleep aid) 2 mg at bedtime for sleep. Review of the medical record revealed the resident had not been assessed for the cause of insomnia. Additionally, review of the medical record revealed there were no non-pharmacological alternatives attempted. Interview with the DON on 2/22/06 at 4 PM confirmed no assessment for insomnia had been done.	F 272	In addition, resident #21 will have a hypnotic/sleep assessment completed. The D.O.N. will monitor its completion and will have a review every 6 months. It will be included in the facility's QI plan. The use of hypnotics and melatonin will be monitored by pharmacist, social services, administration, and D.O.N For Resident #22 4. The bowel assessment was completed by the restorative nurse and reviewed by the clinical review committee. D.O.N. will monitor the assessment. This will be included in the facility QI plan. For Resident #13 5. The facility will use a comprehensive sleep assessment on resident prior to being started on a sedative-hypnotic or melatonin. The D.O.N. will monitor with charge nurses. Discussion will occur at monthly chemical review meeting. This will be added to the facility QI plan. The use of hypnotics and melatonin will be monitored by pharmacist, social services, administration, and D.O.N.	4-03-06 3-14-06 4/03/06

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F 272	Continued From page 5 6. Review of the 2/06 physician's orders for resident #18 revealed s/he had orders for Ambien (for sleep) 10 mg for insomnia. Review of the medical record revealed the resident had not been assessed for the cause of insomnia. Additionally, review of the medical record revealed there were no non-pharmacological alternatives attempted. Interview with the DON on 2/22/06 at 4 PM confirmed no assessment for insomnia was done. 7. Review of the medical record revealed resident #6 had a diagnosis of insomnia dated 3/23/04. Review of the February 2006 physician orders, showed the resident had an order dated 10/28/05 for Ambien (a sleep aide) 5 milligrams PRN (as needed) for insomnia. The February medication administration record confirmed the resident received the Ambien six times so far in the month. Interview with the DON on 2/22/06 at 4 PM confirmed there was not an assessment completed to address the use of Ambien for the insomnia, and she was unaware of any other interventions tried to treat the insomnia. Reference for professional standard related to sleep assessments: According to Nursing Interventions and Clinical Skills, 3rd edition, 2004, by Elkin, Perry and Potter, page 224, a sleep assessment should include assessing at least the following: a. What time the resident usually goes to sleep. b. How quickly the resident falls asleep. c. The average number of hours the resident sleeps. d. How many times the resident awakens during the night. e. When the resident typically awakens. f. How long the resident has had problems	F 272	6. The facility will use a comprehensive sleep assessment on resident prior to being started on a sedative-hypnotic or melatonin. The D.O.N. will monitor. Discussion will occur at monthly chemical review meeting. This will be added to the facility QI plan. The use of hypnotics and melatonin will be monitored by pharmacist, social services, administration, and D.O.N. 7. The facility will use a comprehensive sleep assessment on resident prior to being started on a sedative-hypnotic or melatonin. The D.O.N. will monitor. Discussion will occur at monthly chemical review meeting. This will be added to the facility QI plan. The use of hypnotics and melatonin will be monitored by pharmacist, social services, administration, and D.O.N.	4-03-06 4-03-06

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F 272	Continued From page 6 sleeping and how often. g. What medications might interfere with sleep, h. What illnesses or conditions might alter sleep patterns.	F 272		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		

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F 278	Continued From page 7 Based on medical record review and staff and resident interviews, the facility failed to assure Minimum Data Set (MDS) assessments were accurate for three of ten sample residents (#6, #10, #16). The findings were: 1. Review of the 10/24/05 annual MDS assessment revealed resident #10 did not have any fractures in the past 180 days. However, review of a 6/25/05 x-ray report revealed the resident had fractures to the lateral right 6th and 8th ribs. In addition, the 1/24/06 quarterly MDS assessment revealed the resident was incontinent of bowel. However, review of the 1/24/06 care plan and nursing assistant documentation for that timeframe revealed the resident was continent of bowel. During an interview on 2/22/06 at 4:50 PM, the director of nursing (DON) stated the assessments were inaccurate. 2. Review of the 1/18/06 quarterly MDS assessment showed resident #16 did not have fractures in the past 180 days. However, review of a 12/2/05 x-ray report showed the resident had a fracture to the left rib. Review of nursing notes showed on 12/2/05 the resident fell and suffered fractures to the left ribs. During an interview on 2/21/06 at 4:10 PM, the resident stated she fell and broke two ribs. During a interview on 2/22/06 at 4:50 PM, the DON stated the assessment was inaccurate. 3. The following concerns with accurate completion of significant change assessments for resident #6 were identified: a. Review of the medical record showed the facility completed a significant change MDS assessment for the resident on 11/25/05. According to that assessment, the resident had a	F 278	The MDS coordinator will review MDS for Resident #10 & all residents. 1. The MDS will then be reviewed at care plan meeting to determine accuracy of the MDS, as a double check. D.O.N. will monitor the accuracy of MDS assessments and data entry. We now have a certified MDS-RN completing data entry starting February 28, 2006. The MDS assessments and accuracy will become part of the facility QI plan.	4-03-06
			for #16 2. The MDS will then be reviewed at care plan meeting to determine accuracy of the MDS, as a double check. D.O.N. will monitor the accuracy of MDS assessments and data entry. We now have a certified MDS-RN completing data entry starting February 28, 2006. The MDS assessments and accuracy will become part of the facility QI plan.	4-03-06
			#6 3. a. The MDS will then be reviewed at care plan meeting to determine accuracy of the MDS, as a double check. D.O.N. will monitor the accuracy of MDS assessments and data entry. We now have a certified MDS-RN completing data entry starting February 28, 2006. The MDS assessments and accuracy will become part of the facility QI plan.	4-03-06

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F 278	Continued From page 8 stage 2 ulcer. Interview with the DON on 2/22/06 at 4 PM revealed during this time period the resident never had a stage 2 ulcer and confirmed the coding was inaccurate. b. According to this significant change MDS assessment completed on 11/25/05, the resident was occasionally incontinent of bladder; this was a decline in urinary incontinence since the 8/26/05 quarterly MDS assessment where the resident was documented as "usually continent" of bladder. Despite completion of a significant change assessment, and the documented decline in urinary incontinence, the facility coded Sections H4 as "No change." Interview with the DON on 2/22/06 at 4 PM confirmed the change in urinary incontinence should have been coded as a decline. According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Section H4 should "document any changes in the resident's urinary continence status as compared to 90 days ago (or since the last assessment if less than 90 days ago).	F 278	3. b. The MDS will then be reviewed at care plan meeting to determine accuracy of the MDS, as a double check. D.O.N. will monitor the accuracy of MDS assessments and data entry. We now have a certified MDS-RN completing data entry starting February 28, 2006. The MDS assessments and accuracy will become part of the facility QI plan.	4-03-06
F 371 SS=D	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of a temperature log, and facility policy and procedure,	F 371		

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F 371	Continued From page 9 the facility failed to ensure cold foods were held at an acceptable temperature in one of three resident refrigerators. The findings were: Observations on 2/21/06 at 7:50 PM, and on 2/22/06 at 3:50 PM, showed the interior temperature of the resident refrigerator located in the main dining room was 44 degrees Farenheit (F). The refrigerator contained resident beverages and snacks including; milk, yogurt and health shakes. Review of a temperature log showed refrigerator temperatures were taken in the morning and evenings for most days of February, 2006. Twenty-one of the recorded 32 temperatures were 42 degrees F or higher. The temperature log further showed that on 2/7/06 a request for maintenance was made. However, interview with the maintenance director on 2/22/06 at 11 AM revealed he was not aware of any problem with the refrigerator. Interview with the dietary manager on 2/22/06 at 3:50 PM confirmed the refrigerator was too warm, and her expectation was for the temperature to be in accordance with the policy. She further stated she was not aware if maintenance had addressed it. Review of the facility policy and procedure "Temperatures of Refrigerators and Freezers" revised February 2000, showed "refrigerator temperatures shall be within the acceptable range 30 degrees to 40 degrees F...At any time any refrigerator or freezer is not within acceptable range it must be reported to the maintenance department immediately." According to Food Code 2005, U.S. Public Health Service, 3-501.16: cold holding of potentially hazardous foods shall be maintained at...(a) 5 degrees Celsius (41 degrees F) or less.	F 371	The facility will ensure cold foods will be held at acceptable temperatures . . . (a) 5 degrees Celsius (41 degrees F) or less. See revised dietary policy on temperatures of refrigerators and freezers. Dietary department leader will conduct in-service with staff. See attached in-service meeting attendance sheet. The Dietary department staff will include monitoring of temperatures on daily compliance rounds. This indicator will be included in the facilities QI plan. Dietary Department Leader will monitor this. The maintenance department will conduct bi-annual preventative maintenance of freezers and refrigerators in the facility.	3-14-06

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A050	A. BUILDING _____ B. WING _____	3/20/06 KS 02/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 10	F 456		
F 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to maintain resident equipment in a safe and comfortable manner for one (#21) of nine sample residents. The findings were: On 2/21/06 at 5:20 PM observation revealed the right arm of the wheelchair utilized by resident #21 had rips and tears with sharp edges. Interview with the resident on 2/21/06 at 7:20 PM revealed s/he would like to get "duct tape" to fix it but s/he could not afford the expense. Periodic observations on 2/22/06 from 7 AM through 1:40 PM revealed the right arm of the wheelchair still did not have the rips and tears covered or repaired. Interview with the director of nursing (DON) on 2/22/06 at 1:40 PM revealed the wheelchair arms were normally covered with sheepskin. The DON further stated the sheepskin covers were washed on 2/19/06 (4 days earlier) and should have already been placed back on the wheelchair arms.	F 456	For Resident #21 = all Residents The facility will maintain resident equipment in a safe and comfortable manner. The wheelchair arm rests have been replaced. Sheepskin can also be used as necessary. Staff will be in serviced on importance of maintaining resident's equipment to prevent injury and infection. Resident's equipment will be monitored monthly per safety committee and maintenance requests will be completed for repairs when necessary. Requests versus repair and time frame to complete will be monitored in QI committee. D.O.N. will monitor this.	3-13-06 4-03-06
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure a back flow prevention device was present on a beauty shop sink to protect the water system. The findings were: Observation and interview with the maintenance director on 2/22/06 at 11 AM revealed the beauty shop sink was equipped with a sprayer hose, which could reach the bottom of the sink and did not have a back flow prevention device. Interview with the maintenance director at this time confirmed the back flow device was absent and verified that he was aware the sink should have had one.	F 465	The facility will ensure that a back flow prevention device is placed on beauty shop sink. D.O.N. and maintenance will monitor this. The indicator of providing a safe, functional, sanitary and comfortable environment will become part of facility's QI plan.	4-03-06