POC accepted 8/20/12

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

PRINTED: 07/24/2012
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
Healthcare Licensing	53A050	A. BUILDING _____ B. WING _____	C 07/11/2012

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

(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 The following common abbreviations are used throughout this document: DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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.	F 278	The facility will ensure that all MDS's are coded correctly. This will be accomplished by: 1. The MDS Coordinator will be educated on coding for bowel incontinence, J1900 falls, and M0150 pressure sores. August 25, 2012 2. The MDS Coordinator will be educated that the use of the Braden Scale does not confirm risk of pressure sore that nursing judgment is an important tool also. August 25, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8/1/12

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.

POC accepted. Carol to Don Herbert, Admin. on 8/20/12 @ 2:32pm – left message.

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the MDS assessments were completed accurately for 2 of 9 sample residents (#20, #22). The findings were: 1. Review of the 12/23/11 annual MDS assessment revealed resident #22 was always incontinent of bowel. The 6/11/12 quarterly MDS assessment indicated the resident was now continent of bowel. However, review of the activities of daily living (ADL) flow sheets dated 5/29/12-6/3/12 (during the look-back period of the assessment) showed the resident was incontinent of bowel 12 times. During an interview on 7/11/12 at 4:05 PM the DON stated the resident should have been coded as a "3" (always incontinent) for bowel incontinence on the 6/11/12 MDS assessment. 2. Review of the 4/13/12 quarterly MDS assessment showed resident #20 fell since the prior assessment (item J1800). According to the MDS form, if J1800 is coded for a fall, then item J1900 should be coded for the severity of the fall(s). However, review of J1900 showed no falls were coded. On 7/11/12 at 4:05 PM, the DON stated item J1900 should have been coded as a "1" for A; fall with no injury. The 4/13/12 quarterly MDS assessment indicated the resident was not at risk of developing pressure ulcers (item M0150). However, review of the prior admission MDS	F 278	3. A quality improvement monitoring tool will be implemented by the MDS Coordinator to ensure continuity of coding on the MDS. This monitor will be completed monthly, and reported quarterly at the QI meeting. Appropriate follow-up actions will be initiated by the QI committee. August 25, 2012 #22 Next review of the MDS will reflect proper coding (3) for frequently incontinent of bowel. A note will be written in progress notes explaining the change for coding. #20 No changes will be made at this time to the MDS for J1900. Next review will reflect coding, that she is at risk for pressure ulcers. A note will be written in the progress notes explaining the change for coding.	

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F 278	Continued From page 2 assessment, dated 1/17/12, showed the resident was at risk for pressure ulcers, and was admitted with a stage 2 pressure ulcer. According to the 4/5/12 Braden Scale, the resident was at mild risk for pressure ulcers. During an interview on 7/11/12 at 4:05 PM, the DON confirmed the resident was at risk for pressure ulcers, and the MDS assessment should have reflected that.	F 278		
F 354 SS=E	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility staffing schedules and staff interview, the facility failed to ensure services of a registered nurse for at least 8 consecutive hours each day. The facility census was 24. The findings were: Review of the May, June, and July 2012 nursing schedules showed the facility failed to have a registered nurse on duty for eight consecutive hours on 5/16/12, 5/31/12, 6/1/12 and 6/17/12.	F 354	The facility will ensure that there is RN coverage 8 hours a day 7 days/week. This will be accomplished by: 1. Will ensure 8 hours of RN coverage 7 days/week and have this documented on the schedule. August 25, 2012 2. A quality improvement monitoring tool will be implemented by the DON to ensure there is 8 hours coverage 7 days/week. This monitor will be completed monthly, and reported quarterly at the QI meeting. Appropriate follow-up actions will be initiated by the QI Committee. August 25, 2012	

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F 354	Continued From page 3 During an interview with the director of nursing on 7/11/12 at 3:30 PM, she stated the facility did not have registered nurse coverage on some days, and relied on adjacent hospital registered nurses to come to the facility if an issue warranted.	F 354	There has been RN coverage 8 hours a day 7 days/week from 7/10/12 ongoing with proper documentation on the schedule.	July 10, 2012
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medications were available for use for 2 of 9 sample residents (#2, #21). The findings were: 1. Review of physician's orders for resident #21	F 425	The facility will ensure that the residents receive medications and treatments as ordered by the physician. This will be accomplished by: 1. If resident is out medication the nurse will notify the DON and an employee will be sent to the local pharmacy to pick up the medication so the resident will receive their daily medication without an interruption in their medication regimen. 2. The Policy and Procedure will be reviewed and changes made to show the above back up plan to obtaining medications for residents. 3. If medications cannot be obtained from the local pharmacy the nurse will obtain the medication from the hospital pharmacy. 4. A quality improvement monitoring tool will be implemented by the DON to ensure medications are delivered in a timely manner from the local pharmacy. This monitor will be completed monthly, and reported quarterly at the QI meeting. Appropriate follow-up actions will be initiated by the QI committee. 5. Nurses will be educated on the changes to the policy and procedure by August 25, 2012. 6. If Hospice is unable to supply medications in a timely manner the medication will be ordered from the local pharmacy to ensure proper administration.	August 25, 2012

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F 425	Continued From page 4 showed an order dated 1/4/12 for Celexa (antidepressant) 10 milligrams (mg) once daily. According to the MAR, the Celexa was scheduled to be given at 8 AM. Further review of the MAR showed the Celexa was not given on 7/2/12. The note on the back of the MAR indicated the medication was "not available" from the pharmacy. 2. Review of the medical record for resident #2 showed s/he had diagnoses which included chronic pain and edema. Review of physician's orders showed the resident had a 2/27/12 order for lidocaine 5% ointment topically daily at 10 PM. Review of the MARs showed the lidocaine was not administered on 3/21/12 and 3/29/12. The note on the back of the MAR indicated the medication was "not available" and the facility waited for delivery from the contracted hospice. Further review of physician's orders showed the resident had a 2/13/12 order for Lasix 20 mg twice a day. According to the back of the MAR, the Lasix was not given on 7/2/12 for either the 8 AM dose or the 2 PM dose, and the facility failed to obtain the Lasix until delivery from the contracted hospice on 7/3/12. 3. During an interview on 7/11/12 at 2:15 PM, the DON stated there were issues with the pharmacy for about a month now. She stated if a medication was not available, the nurses were supposed to notify her, so that she could call the pharmacy to obtain the medication that day.	F 425	#21 If resident is out medication, the nurse will notify the DON and an employee will be sent to the local pharmacy to pick up the medication so the resident will receive their daily medication without an interruption in their medication regimen. August 25, 2012 #2 If resident is out medication the nurse will notify the DON and an employee will be sent to the local pharmacy to pick up the medication so the resident will receive their daily medication without an interruption in their medication regimen. Shopko Pharmacy was contacted on 7/30/12 to set up a meeting to discuss the importance of availability of medications and the facility's changes to the policy and procedure for obtaining medications for residents. The meeting with Shopko Pharmacy will take place by August 25, 2012, and will include some type of action. August 25, 2012	