PRINTED: 07/31/2013
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	07/17/2013

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: CNA- Certified Nurse Aide DON- Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to accommodate the needs for positioning during meals for 1 of 9 sample residents (#15) during 3 of 3 meals observed. The findings were: Observation of resident #15 on 7/15/13 at 8:04 AM, 7/16/13 at 12:32 PM and 7/16/13 at 5:20 PM revealed the resident was seated in a chair at an assisted dining table. There was a cushion on the seat so the resident sat higher in the chair. However, the resident's feet did not reach the floor. On 7/16/13 at 5:56 PM CNA #1 said a cushion was placed in the chair about "a couple" of weeks ago so the resident would sit up higher	F 246	The facility will accommodate all residents' needs for proper positioning during meals. This will be accomplished by: 1) Resident #15 has support underneath her feet during meals in the dining room.	07/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Johnson BSW | TITLE: Admin | (X6) DATE: 8-7-13

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. Cael to Amy Johnson, Admin on 8/16/13 @ 10:25am.
Jennifer Cole, OTR/L

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F 246	Continued From page 1 in the chair. The CNA further stated a stool had never been used to support the resident's feet. When asked about it on 7/16/13 at 5:57 PM, the interim DON stated she was unsure why the resident was not using a stool. The DON brought over a cardboard box and placed it under the resident's feet. The DON asked the resident if that was more comfortable, and the resident said "yes."	F 246	2) All residents will be observed in the dining room to ensure that they have their feet reaching the floor or that they have supportive equipment to rest their feet on during meals.	07/17/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility documentation, the facility	F 280	3) Education will be provided to nursing staff and social services staff stating that upon admission and at each care plan meeting, residents are to be observed for positioning and comfort at meal times in the dining room. 4) The DON or designee will observe positioning of all residents in the dining room to ensure proper positioning and comfort 3x per week, one for each meal, for 3 weeks, then 1x per week for 2 months and then monthly thereafter. The results of these observations will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	08/31/13 08/31/13

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F 280	Continued From page 2 failed to ensure the care plan was updated with individualized interventions for 2 of 9 sample residents (#8, #21). The findings were: 1. Review of the care plan dated 6/21/13 showed resident #21 wandered and had aggressive behaviors. Interviews with staff and medical record review revealed the following: a. On 7/16/13 at 4 PM the activity director stated when the resident wandered, she approached the resident and said "I need a break. Can you walk with me?" She stated that approach worked best with the resident, because it gave him/her a purpose. b. During an interview on 7/16/13 at 4:21 PM CNA #2 stated the resident liked the facility cat, and wandered to find it. The CNA stated the resident had a fake cat that staff could give to him/her, which helped. c. Review of activity documentation for May 2013 showed the resident liked to color. One note dated 5/2/13 stated "...Spent several hours in the activity room coloring. Seemed to help with agitation." Further review of the care plan showed the aforementioned interventions were not included. The care plan listed generic approaches, such as "offer diversional activities." 2. Review of the care plan dated 6/14/13 revealed resident #8 displayed agitated behavior during cares. Further review showed generic interventions such as "diversional activities" and "encourage resident to ventilate feelings" were listed. Review of facility documentation and staff interview showed the following individualized approaches were utilized with the resident, but were not included in the care plan: a. Review of facility documentation provided	F 280	The facility will develop comprehensive care plans for all residents. The residents have a right to participate in planning their care and treatment. These care plans will be individualized and specific to each resident's needs. This will be accomplished by: 1) Resident #8 and #21's care plans have been updated to included individualized interventions identified. 2) All residents' care plans will be reviewed by the DON, MDS coordinator and social services department to ensure they are individualized and updated. 3) The DON will provided education to all care center staff regarding the need for all interventions to be added to the residents' care plans. Staff who are aware of interventions utilized are to inform the charge nurse, who is to then add this to the care plan. 4) IDT will review, update and check for accuracy 6 resident care plans each week x4 weeks with an audit tool ensuring that all care plans are reviewed in this period. They will then review each care plan during their quarterly assessment period and sign on the care plans that they have been reviewed for accuracy. 5) The DON or designee will ensure compliance with quarterly care plan reviews. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	~~07/17/13~~ ~~08/15/13~~ ~~08/15/13~~ 08/31/13 08/31/13

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F 280	Continued From page 3 by the social services director showed staff asked the resident about his/her family or the military to redirect him/her. In addition, when the resident swore, staff told the resident there were ladies around. b. During an interview on 7/16/13 at 4:21 PM CNA #2 stated snacks helped calm the resident down. c. Review of activity documentation dated 7/16/13 showed "started to talk and cuss. Went over and started gently rubbing [his/her] shoulders...calmed right down." 3. During an interview on 7/17/13 at 10 AM, the social services director confirmed the care plans for residents #21 and #8 were "not as individualized as could be." She stated not all interventions that staff utilized for behaviors were on the care plan.	F 280		
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	F 425		

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F 428	Continued From page 4 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that 4 of 8 multi-dose vials of insulin that were open and available for use were labeled with the date opened. The following concerns were identified: Observation of the facility's only medication cart on 7/17/13 at 8 AM revealed that of 8 vials of insulin stored in the cart and opened and available for use, only 4 were marked with the date they were opened. All 4 of the undated and opened vials of insulin had reduced amounts of insulin in them, indicating use. Interview with the DON on 7/17/13 at 8:05 AM confirmed that 4 of 8 vials of insulin were opened and undated, and further confirmed the facility policy is to discard opened insulin vials after 30 days.	F 428	The facility will provide medication to the residents in safe and professional manner complying with all standards of medication safety. Vials of opened medication will have an open date recorded on them. All vials of medication will be discarded 30 days after the open date. This will be accomplished by: 1) The insulin bottles identified without an open date have been removed from the medication cart and destroyed. 2) The medication cart will be checked to ensure all vials have an open date labeled and that the open date is less than 30 days. 3) The DON will provide education to the nursing and pharmacy staff regarding the need to check all medication vials to ensure there is an open date and that the open date is less than 30 days old. 4) The pharmacist will audit the medication cart weekly x2weeks, then monthly there after to ensure all medication vials are properly labeled with an open date and that the open date is less than 30 days old. 5) The DON or designee will ensure the audits by the pharmacist are completed. The results will be recorded on the quality calendar and reported to the Quality Advisory Committee. The results will be included in the facility-wide continuous quality improvement program.	07/17/13 07/17/13 08/31/13 08/31/13 08/31/13