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Healthcare Licensing and Surveys

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

PRINTED: 03/24/2016
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 ______	03/10/2016

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 A recertification survey was conducted at the facility by the Office of Healthcare Licensing and Surveys on 3/7/16 through 3/10/16. The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set mg milligrams PRN Pro re nata; as needed RD Registered Dietitian Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature] RN BSN NHA
TITLE
(X6) DATE 3/31/16

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. DOC - 4/30/16. Notified Derek Greenwald, NHA on 3/9/16 @ 12:05pm. [signature], OHLS

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F 225	Continued From page 1 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures and personnel files, and staff interview, the facility failed to ensure the nurse aide registry was checked during the screening process for 4 of 4 newly-hired CNAs (#1, #2, #3, #4) reviewed. The findings were: 1. Review of personnel files on 3/9/16 at 1:40 PM with the human resources (HR) generalist revealed no documentation to show the nurse aide registry was checked prior to hire for the following CNAs: a. CNA #1 hired 2/28/16 b. CNA #2 hired 2/17/16 c. CNA #3 hired 2/8/16 d. CNA #4 hired 1/14/16	F 225	**The facility will ensure all CNA staff have a completed abuse registry prior to hiring. Verification of the completed abuse registry will be placed in their employee file. This will be accomplished by:** **a) CNA #1, #2, #3, and #4 have each had the abuse registry completed and the completed form has been placed in the employee file.** **b) All CNA staff currently employed have had their employee files checked to ensure they have abuse registry verification in their employee file.** **c) All HR staff have been educated on the necessity of completing the abuse registry for the CNA staff upon hire, and ensuring that the verification of the abuse registry check is placed in the employee files.** **d) The DON or designee will perform audits for all newly hired CNAs weekly for 2 months, then monthly for 2 months, then quarterly. 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.**	**03-10-2016** **03-10-2016** **03-10-2016** **04-20-2016**

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F 225	Continued From page 2 During an interview at the time of the observation, the HR generalist stated they did not print out or document when the nurse aide registry was checked. 2. Review of the facility's "Abuse Prohibition Program" policy, revised 1/13, revealed "...Licensure, Certification and/or Registration verification will be performed on all potential SVMC/SVCC [facility name] employees. This includes a review of the State Nurse Aide Registry."	F 225		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy and procedure review, and staff and resident interview, the facility failed to assess the effectiveness of pain medications for 3 of 4 sample residents who required pain management (#16, #18, #21). The findings were: 1. Review of the 1/25/16 significant change MDS assessment revealed resident #21 had a diagnosis of rheumatoid arthritis and had frequent pain, which s/he rated at a "7" (on a scale from 0 to 10). Review of physician orders revealed in	F 309	**The facility will ensure all residents are assessed for the effectiveness of pain medication and the results of this assessment documented in the electronic medical record (EMR). This will be accomplished by:** **a) Resident #21 has been assessed by the nurse to verify that her pain goals are being met with their current pain management regimen.**	**03-30-2016**

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F 309	Continued From page 3 addition to routine pain medication, the resident had an order for Norco (opioid pain medication) 5/325 mg 2 tabs every 6 hours PRN for pain, and also Ultram (opioid pain medication) 50 mg to 100 mg 4 times per day PRN for pain. Review of the MAR from 2/1/16 through 3/8/16 revealed the resident received the PRN Norco 40 times and the PRN Ultram 18 times for pain. Review of the medical record, including nursing notes for that time period, showed the effectiveness of the PRN pain medications was only documented twice. 2. Review of the 12/7/15 significant change MDS assessment showed resident #16 had arthritis and had pain occasionally, which s/he rated as a "4" (on a scale of 0 to 10). Review of physician orders showed the resident had an order for Norco 5/325 mg 1 to 2 tabs every four hours PRN for pain. Review of the MAR for 2/1/16 to 3/8/16 showed the resident received the PRN Norco 57 times. Review of the medical record, including nursing notes for that time period, revealed the effectiveness of the PRN pain medication was only documented 6 times. 3. Review of the 1/4/16 quarterly MDS assessment showed resident #18 received scheduled and PRN medications for pain. Interview on 3/9/16 at 9:30 AM with resident #18 revealed s/he had a vertebrae injury many years ago and currently preferred to stay in bed most of the time because it was less painful than sitting. S/He further stated the pain medications "helped" at times. Review of the 1/6/16 physician's note showed the resident had longstanding back pain due to arthritis and an old injury, "not well controlled on Tylenol #3, alternating with Hydrocodone APAP [Norco]..." Review of the physician's orders showed Norco 2 tablets every	F 309	**b) Resident #16 has been assessed by the nurse to verify that her pain goals are being met with their current pain management regimen.** **c) Resident #18 has been assessed by the nurse to verify that her pain goals are being met with their current pain management regimen.**	**03-30-2016** **03-30-2016**

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F 309	Continued From page 4 6 hours PRN was ordered on 10/26/15, and Tylenol #3 one to two tablets every 6 hours PRN was ordered on 7/29/15. Review of the medical record, including the nursing notes, showed staff did not complete assessments for effectiveness after administering the following PRN pain medications: a. Tylenol #3 was administered 39 times in February 2016, and 12 times from 3/1/16 to 3/8/16. b. Norco was administered 56 times in February 2016, and 11 times from 3/1/16 to 3/8/16. 4. During an interview on 3/9/16 at 10:55 AM, the DON stated the facility needed to "work on" pain management. She stated the computer system used to make the nurses document the effectiveness of the pain medication, but that "went away." She stated the facility policy did not address documenting the effectiveness of PRN pain medications, but her expectation was that nurses would assess and document the effectiveness of PRN pain medication. She further stated the facility was going to be revising their pain management policy, and would be using Lippincott as a reference/guide. Review of the facility's policy "Pain Management Program" (revised 2/29/08) confirmed it did not address evaluating and documenting the effectiveness of pain medication. Review of the printed-out material from Lippincott ("Pain assessment, long-term care," revised July 10, 2015) provided by the DON during the interview showed "...you should reassess a resident for pain after every intervention or treatment."	F 309	**d) All residents have been assessed by the nurse to verify that their pain goals are being met with their current pain management regimen.** **e) The Pain Management Program policy will be updated to address the pain medication effectiveness assessment and the EMR documentation of this assessment.** **f) Meditech, the facility EMR, will be programmed to assist in reminding nursing staff that pain medication effectiveness assessments are necessary following administration of pain medications, either routine or PRNs.** **g) Education to all nurses regarding the pain medication effectiveness assessment and the EMR documentation of this assessment. Emphasis will be placed on ensuring that this assessment is completed regardless of whether or not the EMR reminds them.** **h) DON or designee will perform audits 3x/week for 2 weeks, then weekly for 1 month, then monthly on completion and documentation of pain medication effectiveness assessments. 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.**	**04-08-2016** **04-20-2016** **04-20-2016** **04-20-2016** **04-20-2016**

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure cold beverages were held at the proper holding temperature during 1 of 2 meals observed. The findings were: 1. Observation on 3/7/16 at 5 PM revealed cold beverages, including 10 individual cartons of milk, had already been placed on tables in the dining room. The posted meal time was 5:30 PM. At 5:25 PM the surveyor requested that the RD take the temperature of one of the cartons of milk. The RD used a facility thermometer and obtained a temperature of 48 degrees Fahrenheit (F). The RD then used a second facility thermometer to check the temperature of the same carton of milk and obtained a temperature of 44 degrees F. He confirmed the temperature of the milk was above the allowed 41 degrees F. 2. During an interview on 3/9/16 at 3:10 PM the dietary manager stated the facility did not routinely monitor the temperatures of the beverages, because they normally took beverages out of the refrigerator closer to meal	F 371	**The facility will ensure cold foods are held at the proper holding temperature. This will be accomplished by:** **a) Cold beverages will be served at the appropriate temperatures. Cold beverages will be left in a refrigerated environment until 10 minutes prior to the resident arriving to the dining room.** **b) The Dietary Manager will provide the dietary staff with education on appropriate temperatures of cold beverages, as well as appropriate times to serve the residents their cold beverages.** **c) The Dietary Manager or designee will perform audits 3x/week for 2 weeks, then weekly to ensure cold beverages are not provided until 10 minutes prior to the resident arriving to the dining room and that they are served at the appropriate temperatures. The audit 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.**	04-08-2016 04-08-2016 04-20-2016

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F 371	Continued From page 6 times. He stated the evening meal on 3/7/16 was unusual because of staff training. 3. According to the Food Code 2013, U.S. Public Health Service, 3-501.16 Time/Temperature Control for Safety Food, Hold and Cold Holding, "...Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 degrees C (135 degrees F) or above....or (2) At 5 degrees C (41 degrees F) or less."	F 371		