POC approved 6/27/11 JC

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

PRINTED: 06/10/2011
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
	53A060	A. BUILDING _____ B. WING _____	C 05/26/2011

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: CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 278 SS=B	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	F 278		

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.

RECEIVED
JUN 20 2011
Wyoming Department of Health

Changed mode by Janelle Conlin, ORN, per instructions of Jean Porter, NHA during phone call on 6/27/11 @ 2:05pm. JC

Office of Healthcare Licensing and Surveys

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 _____	C 05/26/2011

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 LSO 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 278	Continued From page 1 assessment. 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 MDS assessments were signed as required for 4 of 10 sample residents (#10, #11, #21, #22). The findings were: 1. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, the RN coordinator signs and dates at section V0200 B1 and B2 which certifies that the CAAs have been completed. A staff member signs and dates section V0200 C1 and C2 after the care plan is complete. The following concerns were identified: a. Review of the 4/6/11 significant change MDS assessment for resident #11 showed Section V0200 B1 was not signed by the RN coordinator. In addition, Section V0200 C1 also lacked a signature. b. Review of the 1/21/11 annual MDS assessment for resident #21 showed there were no signatures at section V (V0200, B and C). c. Review of the 1/12/11 annual MDS assessment for resident #22 showed there was no signature at section V (V0200, B) for the MDS coordinator. In addition, the corresponding CAAs for dental care, ADLs, urinary incontinence, falls, and pressure ulcers were not signed.	F 278	F278 Facility will ensure that all MDS's are Signed. This will be completed by: The e-signature has been activated on MDS Program to ensure all MDS will have staff Name,section & date completed. The MDS coordinator will review all MDSs Prior to being filed for signatures. All MDSs have been reviewed for proper Signatures. A quality improvement tool will be put into place. It will be monitored weekly & Reported to the facilities continuous Quality improvement committee thru the Quality calendar. Dir. of Nursing will Monitor this. Completed. 1a. the MDS for res #11 was reviewed & signed. 1b. The MDS (for res #21 was reviewed & signed. 1c. The MDS and CAAs (for res #22 were reviewed & Signed. 2, The MDS Section Z (for res #10 was reviewed & signed. 3. The Dir. of Nursing/MDS coordinator will Review all MDSs prior to filing for all Signatures. This will be documented weekly On quality monitoring tool & reported monthly To facility-wide continuous quality improve-Ment committee. This is completed.	June 14, 2011 July 1, 2011

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 _____	C 05/26/2011

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 278	Continued From page 2 2. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, September 2010, at Section Z0500, the RN assessment coordinator must sign, and thereby certify the assessment is complete. However, review of the 3/10/11 quarterly MDS assessment for resident #10 revealed the RN assessment coordinator failed to sign at Section Z0500. 3. During an interview on 5/26/11 at 1:55 PM, the DON confirmed the assessments were lacking the necessary signatures. She stated "I usually sign those," and was not sure how they were missed.	F 278		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for kitchen staff in one of one walk-in freezers. The findings were: Observation of the kitchen walk-in freezer on three consecutive days (05/24/11 at 1:45 PM, 05/25/11 at 8:58 AM and at 3:48 PM and then again on 05/26/11 at 11:11 AM) revealed an approximate 1 foot (ft) by 2 ft by 1/2-inch sheet of ice on the floor. The ice was directly underneath a ceiling-mounted condenser. Interview with the	F 465	F 465 Facility will provide a safe environment For kitchen staff regarding walk-in freezer. Facility will adjust refrigeration unit freeze & Thaw cycles. This eliminated condensation. There is no ice build-up on floor. The Facilities dept. leader will monitor this with Food services dept. leader. This will be added To facility-wide continuous quality improvement Program. This is complete.	June 14, 2011

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 _____	C 05/26/2011

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 465	Continued From page 3 dietary manager on 05/26/11 at 11:11 AM acknowledged the ice on the floor was coming from the condenser and constituted a fall hazard for staff. In addition, the manager stated plans were in the works for the problem to be resolved "now that a maintenance manager was hired several weeks ago."	F 465		
F 492 SS=B	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and staff interview, the facility failed to ensure it was in compliance with federal regulations pertaining to nurse aide training for 2 of 6 CNAs hired in the past year. The findings were: During an interview on 5/26/11 at 8:15 AM, the DON and administrator stated they did not believe CNAs who were hired within 12 months of completing a nurse aide training and competency evaluation program were reimbursed for the costs associated with the program. The administrator stated that issue was brought up by the instructor of the nurse aide program, but the facility had not resolved the issue yet. According to a list provided by the human resources (HR) director, of the six CNAs hired in the past year, two would have completed the nurse aide training program	F 492	F492 Facility will be in compliance with 42 CFR 483.152. Facility will have policy to Outline process to reimburse CNA for costs Associated with nurse aide training & Competency evaluation program. This policy Will be presented for approval by the facility-wide Compliance Advisory committee & administrative Team. HR Director will monitor and report on this. CNAs meeting above criteria will be reimbursed. This will be completed by this will be monitored by the facility Quality Improvement Program. jc	July 08, 2011

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 _____	C 05/26/2011

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 492	Continued From page 4 within 12 months of being hired by the facility. On 5/26/11 at 9:35 AM, the HR director stated neither of the CNAs had been reimbursed for costs associated with the nurse aide training and competency evaluation program. According to 42 CFR [Code of Federal Regulations] Subpart D, 483.152, "(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials). (2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide."	F 492		