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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 by Healthcare Licensing and Surveys from 4/29/19 to 5/2/19. DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant ADON: Assistant Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		5/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/22/2019

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to maintain resident dignity for 1 of 12 sample resident (#7). The findings were: 1. Review of the annual MDS assessment for resident #7 dated 2/20/19 showed the Brief Interview for Mental Status (BIMS) score was 15/15 (indicating intact cognition), and had diagnoses which included arthritis, osteoporosis, weakness, chronic venous stasis dermatitis, kyphosis, and a history of falls. Further review showed the resident required extensive assistance for bed mobility, transfers, and toilet use. Review of the resident care plan titled "ADL impairment" showed bed mobility required the extensive assistance of 2 persons, transfers required limited assistance of 2 persons, and toilet use required the extensive assistance of 2	F 550	A. Immediate Action Taken: The resident's dignity was protected when the Care Plan for the resident in room 205, identified as Resident #7 in the State Survey, was updated to reflect physical therapy's assessment that this resident could be transferred using a 1 person assist. All staff were informed that they could use a 1 person assist to transfer her. B. The Potential to Affect Other Residents: All resident Care Plans are to be reviewed to make sure that what is actually being done with ADL care is what has been determined appropriate by therapy services, nursing services, and physicians. Completed 5/22/2019 C. Systemic Changes: Education was given to all staff at a staff meeting on 5/16/2019 about the proper sequence for	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 550	Continued From page 2 persons. Review of the daily CNA care plan showed transfer-mobility required the extensive assistance of 2 persons. The following concerns were identified: a. Observation on 4/30/19 at 8:39 AM of resident care showed the resident sitting on toilet requesting help for assistance to the recliner. CNA #1 told the resident she couldn't help her/him off the toilet by herself because the "state surveyor" was there. She continued telling the resident that the care plan still showed 2 person assist and with "state" at the facility, she could not help the resident to the recliner by herself. The resident became upset about having to wait for another CNA and informed CNA #1 she could take him/her over to the recliner like any other time. b. Review of CNA ADL report from 4/18/19 through 5/1/19 showed the resident was documented as receiving limited assistance of 1 person or independent with set-up help for transfers on 26 occasions. c. Interview with the resident on 5/01/19 at 4:28 PM revealed the therapist assessed him/her late last week and told him/her only 1 CNA was needed to assist him/her with ADLs. Further, the resident stated on Saturday and Sunday the facility only had one CNA helping him/her and during the survey staff insisted on 2 CNAs. The resident revealed the requirement "upset" him/her and made him/her "mad." d. Interview with DON and ADON on 5/02/19 at 8:39 AM revealed the expectation of staff was to follow the care plan. They confirmed the transfers were going to change to a 1 person transfer; however, the change had not been communicated to CNAs at that time and the care plan had not been updated.	F 550	having ADL changes put into the Care Plan and then being carried out. Any staff not in attendance at the staff meeting was informed about the education given and required to take a quiz. Specifically: If any staff members notice a change in ADL function, the MDS nurse should be immediately notified. The resident□s change will be assessed by nursing and therapy services as appropriate. The change in ADL functioning will be shown in the Care Plan and all staff will be informed of the change either verbally or through the communication books kept at the nurses□ station. D. How Performance Will Be Monitored: The DON or designee will perform audits on 4 different resident Care Plans weekly for 4 weeks, then monthly for 3 months to ensure updates to Care Plans are made in a timely manner and that the Care Plan accurately reflects the care needed to meet the residents□ needs and protect his/her dignity, and that staff are informed of any changes and are following the care plan. Results of these audits will be reported on the monthly quality calendars and reviewed by the quality advisory team monthly.	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 690	Continued From page 3	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		5/22/19

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 690	Continued From page 4 Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure appropriate catheter care was provided for 1 of 4 sample residents (#4) with an indwelling catheter. The findings were: 1. Review of the quarterly MDS assessment dated 2/7/19 showed resident #4 had diagnoses which included neurogenic bladder and multiple sclerosis. Further review showed the resident required total assistance of 2 or more persons for transfers, bed mobility, dressing, toilet use, and personal hygiene. Review of the care plan titled "Risk for infection" dated 2/13/19 showed the resident was at risk for infection due to a supra-pubic catheter. The following concerns were identified: a. Observation on 4/30/19 at 9:13 AM showed CNA #2 and CNA #3 entered the resident's room, applied a full body lift sling, and transferred the resident from the wheelchair to his/her bed. CNA #2 secured the catheter drainage bag to the lift with the drainage bag and tubing positioned above the resident's bladder. Continued observation showed urine in the tubing flowed backwards toward the resident's bladder during the transfer. b. Observation on 4/30/19 at 6:45 PM showed CNA #4 and CNA #5 entered the resident's room, applied a full body lift sling, and transferred the resident from the wheelchair to his/her bed. CNA #5 secured the the catheter drainage bag to the lift with the drainage bag and tubing positioned above the resident's bladder. The CNA removed the bag prior to the resident transfer; however, prior to removal, urine in the tubing flowed backward towards the resident's bladder.	F 690	A. Immediate Action Taken: The resident, identified as Resident #4 in the State Survey, was protected from having her urinary catheter bag raised above the level of her bladder by all direct care staff being re-educated immediately concerning always keeping the bag below the bladder during transfers and at all other times. The rationale of keeping bacteria from back flowing into the bladder was discussed. A hook device was provided that would allow the bag to be easily attached to the lift in a position that would keep the bag below the level of the bladder. All direct care staff was educated regarding its use. B. The Potential to Affect Other Residents: It was determined that any resident with a urinary catheter bag had the potential to be affected. Staff was educated 5/16/2019 to keep all urinary catheter bags below the level of the bladder at all times. C. Systemic Changes: Education was given to all staff at a staff meeting on 5/16/2019 about catheter bags being kept below the level of the bladder at all times and specifically about being vigilant with residents who have urinary catheters and who require mechanical lifts. Any staff not in attendance at the staff meeting was informed about the education given and required to take a quiz. D. How Performance Will Be Monitored: The DON or designee will perform audits by watching care on 2 different residents weekly for 4 weeks, then monthly for 3 months to ensure urinary catheter bags are being kept below the level of the	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 690	Continued From page 5 c. Interview with the DON and ADON on 5/02/19 at 8:39 AM revealed the catheter drainage bag should be kept below the bladder to prevent urine flow back into the bladder, because urine flow back increased the risk of infection. d. Review of the procedure titled "Suprapubic catheter care" last revised 2/15/19 showed "...secure the urine drainage system tubing below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of catheter-associated urinary tract infection (CAUTI)..." e. Review of the policy titled "Mechanical Lift Policy" last revised on 1/2019 showed "...9. Attach resident's catheter bag to the lift if in use, always keeping the catheter bag below the the level of the resident's bladder..."	F 690	bladder at all times. Results of these audits will be reported on the monthly quality calendars and reviewed by the quality advisory team monthly.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700		5/22/19

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 700	Continued From page 6 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure bed rails were assessed for safety for 4 of 4 sample residents (#5, #6, #17, #19) with bed rails. The findings were: 1. Observation on 4/30/19 at 10:05 AM showed resident #5 had a bed rail on the left upper half of his/her bed and the right side of the bed was against the wall. The bed rails were designed with 3 gaps which measured 4 inches by 8 1/2 inches, 4 inches by 8 1/2 inches, and 3 1/2 inches by 8 1/2 inches. The following concerns were identified: a. Review of the medical record showed no evidence the facility completed a safety assessment related to the use of bed rails. 2. Observation on 5/1/19 at 2:37 PM showed resident #6 had a bed rail on the upper left side of the bed and the right side of the bed was placed against the wall. The bed rail was designed with 1 gap which measured 17 inches by 4 inches. The following concerns were identified: a. Review of the medical record showed no evidence the facility completed a safety assessment related to the use of bed rails. 3. Observation on 4/29/19 at 4:59 PM showed Resident #17 had a bed rail attached to the right upper half of his/her bed and the left side of the bed was against the wall. The grab bar was designed with a single gap that measured 17	F 700	A. Immediate Action Taken: All 4 residents, identified in the State Survey as Residents # 5, #6, #17, and #19, who currently have grab bars (bed rails) were assessed to determine if the rails were helpful for the residents who had them on their beds. If not helpful, they were removed. All residents who were helped by having a rail for repositioning themselves on their beds were assessed for the risk of entrapment. The risks and benefits of the rails were reviewed with the resident or resident representatives and informed consent was obtained if the rails were to be used. B. The Potential to Affect Other Residents: Every resident in the facility who has the grab bars installed on their bed is potentially affected. All other residents who currently have grab bars will be assessed and informed as in (A). C. Systemic Changes: All newly admitted residents or existing residents who are to begin using a grab bar will be assessed for grab bar/side rail use. Each newly admitted resident or existing resident who is to begin using a grab bar will undergo the same assessment and will be informed of the risks/benefits of use. D. How Performance Will Be Monitored: The DON or designee will perform audits weekly for 4 weeks then monthly for three	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 700	Continued From page 7 inches by 4 inches. The following concerns were identified: a. Review of the medical record showed no evidence the facility completed a safety assessment related to the use of bed rails. 4. Observation on 4/29/19 at 5:22 PM showed Resident #19 had a bed rail attached to the right upper half of his/her bed and the left side of the bed was against the wall. The grab bar was designed to have 3 gaps which measured 4 inches by 8 1/2 inches, 4 inches by 8 1/2 inches, and 3 1/2 inches by 8 1/2 inches. The following concerns were identified: a. Review of the medical record showed no evidence the facility completed a safety assessment related to the use of bed rails. 5. Interview with the DON on 5/1/19 at 2:14 PM revealed the facility had not completed safety assessments for any of the bed rails in use at that time.	F 700	months, reviewing appropriateness of grab bars in place, making sure assessments are complete for risk of entrapment, and that informed consent of risks/benefits is in place. Residents who currently utilize grab bars will be reassessed every 6 months to ensure use of grab bar is still appropriate. Results of these audits will be reported on the monthly quality calendars and reviewed by the quality advisory team monthly.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		5/22/19

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 758	Continued From page 8 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure appropriate medication use for 1 of 5 sample residents (#70) reviewed with	F 758	A. Immediate Action Taken: The facility's form for the use PRN psychotropic medication greater than 14 days was updated to specify duration of	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 758	Continued From page 9 psychotropic medications. The findings were: 1. Review of the physician orders for resident #70 showed an order for lorazepam (anti-anxiety) 0.5 milligrams (mg) by mouth, three times per day as needed. Further review showed the medication was ordered on 4/12/19 and there was no stop date or rationale for use greater than 14 days. 2. Interview with the social services director on 5/1/19 at 12:46 PM confirmed that the medication order did not have a stop date and revealed a rationale was not received from the physician until 5/1/19. 3. Review of the policy titled "Psychotropic Medication Use" last revised on 9/2018 showed "...8. PRN [as needed] psychotropic medication, not including antipsychotics, may only be used for 14 days unless documented by the primary care physician that it is medically necessary beyond 14 days.	F 758	treatment and rationale for use. The prescribing practitioner has filled out this form with the above specific information for the resident identified in the State Survey as Resident #70. Completed 5/21/2019. B. The Potential to Affect Other Residents: Any resident in the facility who has a PRN order for a psychotropic medication greater than 14 days is potentially affected. All other residents who currently have a PRN psychotropic medication order will have an updated form filled out by the prescribing practitioner specifying duration of treatment and rationale for use by 5/30/2019. C. Systemic Changes: The new form for PRN psychotropic medication use will be filled out by the prescribing practitioner every time a PRN order for a psychotropic medication to be used greater than 14 days is given. D. How Performance Will Be Monitored: The DON or designee will perform audits weekly for four weeks then monthly for three months reviewing the records for each resident with a PRN psychotropic medication to assure the appropriate information is provided by the prescribing practitioner regarding duration of treatment and rationale for use beyond 14 days.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		5/22/19

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 759	Continued From page 10 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professional standards, the facility failed to maintain a medication error rate of five percent or less. The error rate for medication administration pass was 3 errors out of 26 opportunities, resulting in a 11.54 percent error rate. The findings were: 1. Observation during medication administration on 5/1/19 at 9:14 AM showed RN #1 prepared and crushed baclofen (muscle relaxant) 10 mg tablet, riluzole (glutamate blocker) 50 mg tablet, and citalopram hydrobromide (selective serotonin reuptake inhibitor (SSRI)) 40 mg tablet together. The RN then combined the 3 crushed medications in water and administered the medications through resident #18's percutaneous endoscopic gastrostomy-tube (PEG tube). The following concerns were identified: a. Interview with DON and the ADON on 5/02/19 8:58 AM revealed the nurses would crush the medications, mix them together, and administer with water. They confirmed the facility did not have a physician's order for the medications to be given together. Further interview revealed the facility's expectation would be for the nurses to follow the facility policy and procedure. b. Review of the procedure title "Gastrostomy tube drug instillation, long-term care" showed: "...Clinical alert: Don't mix together different medications intended for administration through the gastrostomy tube because of the risks for physical and chemical incompatibility, tube	F 759	A. Immediate Action Taken: A prescribing practitioner's order was obtained to be able to combine crushed medications and administer together in the gastrostomy tube for the resident identified in the State Survey as Resident #18. The pharmacist has reviewed the medication regimen and verified that it is safe/effective to combine the medications and administer together in the gastrostomy tube. B. The Potential to Affect Other Residents: There are currently no other residents with a gastrostomy tube through which crushed medications are administered. C. Systemic Changes: All nurses were educated on 5/16/2019 to refer to the procedures found in Lippincott Procedures for medication administration and when it is necessary to vary from these procedures in the best interest of the individual resident, a prescribing practitioner□s order is to be obtained for that variance. D. How Performance Will Be Monitored: The DON or designee will perform audits weekly for four weeks then monthly for three months observing a medication pass to ensure medications are being administered according to our policies and procedures and that if any variances are in practice in the best interest of the resident, there is a prescribing	

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 _____	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 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 759	Continued From page 11 obstruction, and altered therapeutic drug response...." c. Review of the "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendorf (2016), sixth edition showed: "Implementation for Administering Medications Through A feeding Tube... 13. ...b. To administer more than one medication, give each separately and flush between medications with 15 to 30 ml of water..."	F 759	practitioner□s order for the variance. Medication administration error rate will be tracked monthly. Results of these audits will be reported on the monthly quality calendars and reviewed by the quality advisory team monthly.	