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	53A050	A. BUILDING _____ B. WING _____	06/24/2021

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/21/21 to 6/24/21. The following common abbreviations are used throughout this document: DON- Director of Nursing gm- gram MDS- Minimum Data Set mg- milligram ml- milliliter Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview and staff interview, the facility failed to ensure resident assessments accurately reflected resident status for 2 of 14 residents, (#4,#16). The findings were: 1. Review of the admission MDS assessment, dated 8/20/20, for resident #4 showed the resident was admitted with diagnoses which included non-traumatic brain dysfunction, cancer, diabetes mellitus, and anxiety. The assessment showed the resident received oxygen therapy. Observation on 6/23/21 at 5:08 PM showed the	F 641	F641 Accuracy of Assessments A. Immediate Action Taken: For resident #4, the physician was notified on 6/30/21 and asked to add a diagnosis and an order for her supplemental oxygen. The diagnosis and order for oxygen have been obtained. A significant correction MDS has also been completed for resident #4. For resident #16, a significant correction MDS has also been submitted. B. The Potential to Affect Other Residents: All residents' diagnoses and orders are being cross-checked with the	7/13/21

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

Electronically Signed | 07/15/2021

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F 641	Continued From page 1 resident in his/her room wearing oxygen via nasal cannula. The following concerns were identified: a. Review of the quarterly MDS assessment, dated 5/19/21 failed to show the resident received oxygen therapy. b. Interview on 6/24/21 with the social services nurse confirmed the admission MDS and the quarterly MDS had a discrepancy related to oxygen therapy, which did not accurately reflect the resident's status. 2. Review of the significant change MDS assessment, dated 5/18/21 for resident #16 showed diagnoses which included heart failure, hypertension, chronic venous stasis dermatitis of both lower extremities, diabetes mellitus, and chronic obstructive pulmonary disease. Observation of the resident on 6/22/21 at 2:14 PM showed Coban dressings to both lower legs. Interview with with resident at that time revealed s/he had wounds on his/her legs which were getting better. Observation on 6/22/21 at 4:07 PM showed RN #2 removed the dressings to the resident's lower legs, and an open area was noted to the right lower leg. Interview with RN #2 confirmed the resident had venous stasis ulcers. Review of the physician order's dated 4/8/21 showed an order to apply silver foam to right lower leg twice a week. The following concerns were identified: a. Review of the significant change MDS assessment, dated 5/18/21, failed to show the resident had venous and arterial ulcers. Interview on 6/24/21 at 8:55 AM with the MDS coordinator nurse revealed she failed to document on the MDS assessment the resident had a venous stasis ulcer.	F 641	MDS data to ensure accuracy. C. Systemic Changes: With each quarterly and comprehensive MDS, orders and diagnoses will be cross-checked. Education was given by the DON to all nurses who contribute information to the development of MDS assessments regarding the need for full and accurate information for each residents' therapies, orders, and diagnoses and making sure all is coded accurately on the MDS. This education was completed during the 7/13/2021 nurses' meeting. D. How Performance Will Be Monitored: The DON or designee will perform audits on each MDS assessment to ensure accuracy. Audits will be done initially with every resident MDS and ongoing with each MDS thereafter x 12 months. Results of audits will be reported in the monthly facility-wide QA report and also discussed in detail at the Care Center QAPI every other month. 1.Physician notified and asked to add a diagnosis and an order for supplemental oxygen (resident in room 219, identified as resident #4 in the State Survey). (completed 7/21/21) 1. Diagnosis and order obtained for supplemental oxygen for resident in room 219 (#4). (completed 6/23/21) 2. Significant correction MDS submitted for the resident in room 219 (#4). (completed 7/12/21) 3. Significant correction MDS submitted for the resident in room 217 (#16)	

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F 641	Continued From page 2	F 641	(completed 7/12/21) 4. Education provided by DON to all nurses who contribute to the MDS. (completed 7/13/21) 5. All residents□ diagnoses and orders cross-checked with the MDS to ensure accuracy. (completed 7/14/21) 6. Orders and diagnoses cross-checked with each quarterly and comprehensive MDS. □ (ongoing) 7. MDS audits, initial and ongoing x 12 months. (ongoing) □ see audit record below: F641 Audit Accuracy of Assessments: audits on each MDS assessment to ensure accuracy for the next 12 months. Results of audits will be reported in the monthly facility-wide QA report and also discussed in detail at the Care Center QAPI every other month. Audit of MDS Assessment Accuracy Indicate C for comprehensive, Q for quarterly and initials of person completing audit. July Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun 201 202 203 204 205 206	

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Signature and Title of persons performing

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F 641	Continued From page 4	F 641	audit Signature, title Initials	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		6/30/21

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F 656	Continued From page 5 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure comprehensive care plans were developed to address the medical, physical, mental and psychosocial needs for 2 of 14 residents (#4, #10). The findings were: 1. Review of the admission MDS assessment, dated 8/20/20, for resident #4 showed the resident was admitted with diagnoses which included non-traumatic brain dysfunction, cancer, diabetes mellitus, and anxiety. Review of the physician progress notes dated 6/14/21, showed the resident wore supplemental oxygen. Observation on 6/23/21 at 5:08 PM showed the resident in his/her room wearing oxygen via nasal cannula. The following concerns were identified: a. Review of the care plan on 6/23/21 at 5:08 PM failed to show interventions that reflected oxygen use. b. Interview on 6/24/21 at 10:50 AM with the social services nurse confirmed the resident was on oxygen and the care plan needed to be updated to reflect oxygen use. 2. Review of the significant change MDS assessment dated 2/22/21 showed resident #10 was admitted with diagnoses which included hypertension, osteoporosis, and macular degeneration, and received oxygen therapy.	F 656	A. Immediate Action Taken: For Resident #4 and #10, care plans were updated on 6/30/21 to reflect oxygen use and monitoring. (completed) B. The Potential to Affect Other Residents: All other resident care plans have been reviewed to reflect a comprehensive person-centered care plan for each resident. (completed 7/14/21) C. Systemic Changes: With each quarterly and comprehensive MDS assessment, each care plan will be reviewed by the DON/designee to assure accuracy. Education was given by the DON to all nurses who contribute information to the development of care plans regarding the need for full and accurate information for each residents' therapies, orders, and diagnoses ensuring the accuracy of the care plan. (ongoing) D. How Performance Will Be Monitored: DON or designee will cross-check residents' care plans with each MDS assessment quarterly for accuracy related to diagnoses and orders to ensure person-centered care planning for the next 12 months. (ongoing)	

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F 656	Continued From page 6 Observation on 6/22/21 at 2:53 PM showed the resident was wearing oxygen via nasal cannula. Review of the physician orders, dated 12/17/20, showed an order for oxygen, and daily oxygen monitoring. The following concerns were identified: a. Review of the current care plan failed to show a care area for oxygen and interventions related to oxygen monitoring. b. Interview on 6/24/21 at 8:49 AM with the MDS coordinator nurse confirmed the care plan did not have interventions related to oxygen monitoring and she updated the care plan to reflect oxygen use.	F 656	E. Results of audits will be reported in the monthly facility-wide QA report and also discussed in detail at the Care Center QAPI every other month. (ongoing)	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of bowel movement monitoring forms, the facility failed to ensure interventions were implemented to treat constipation for 1 of 2 sample residents (#20) reviewed for constipation. The findings were: 1. Review of the 1/20/21 initial and the 5/11/21 significant change MDS assessments showed resident #20 received scheduled and as needed	F 684	F684 Quality of Care A. Immediate Action Taken: The bowel treatment protocol was put back on the BM monitoring sheet. Resident #20 has been monitored closely for BM frequency and nurses were re-educated by the DON concerning the bowel treatment protocol and charting interventions given for each stage at the nurses' meeting on 7/13/2021. Resident #20 continues to	7/14/21

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medications for pain and received an opioid medication on 7 days during the observation period. The MDS assessments showed the resident did not have constipation. Review of physician orders showed the resident was prescribed Methadone HCl (an opiod pain medication) 5 mg twice per day for pain. In addition, the resident had orders for Milk of Magnesia 30 ml, Miralax 17 gm, and Fleet enema 4.5 oz rectally as needed for constipation. The following concerns were identified:

a. Review of the bowel movement documentation for June 2021 showed the resident went 8 days without a documented bowel movement (6/11 through 6/18).

b. Review of the "BM Monitoring" nursing documentation showed on 6/14/21 the resident was listed and "Day 3" [without a BM] was marked. No treatment was identified. The resident was listed on 6/15/21 with "Day 4" marked. No treatment was identified. On 6/16/21, "X5" was marked for the resident. No treatment was identified. On 6/17/21 "Day 6? Brown Cow" was written in for the resident. On 6/18/21 "day 7?" was written for the resident, with no treatment identified. On 6/19/21 "X8" was written and "Fleets Enema" was written for treatment, which resulted in a bowel movement.

c. Review of the medication administration record (MAR) and nursing notes for June 2021 showed no interventions were given for constipation until 6/19/21 when the Fleets enema was given.

d. During an interview on 6/23/21 at 11:55 AM the DON stated "Brown Cow" is prune juice and Milk of Magnesia. She stated the resident spit out regular prune juice, so the resident probably spit out the brown cow, which is why it wasn't on the MAR. She confirmed there were no documented

require interventions for constipation related to her opioid use. The floor nurses monitor the frequency of her bowel movements daily and intervene per the bowel movement protocol.

B. The Potential to Affect Other Residents: All residents have the potential to be affected by constipation and BMs are charted daily for each of them. Each resident has been checked to make sure the proper sequence for treatment as outlined in the bowel protocol has been followed.

C. Systemic Changes: Education to be given by the DON to all nurses at the next staff meeting, 7/13/21 concerning bowel protocols to be followed beginning the third day with no bowel movement. All interventions based on the bowel protocol will be documented in the nurses' notes and the MAR as appropriate.

D. How Performance Will Be Monitored: The BM chart and bowel protocol will be reviewed by the DON or designee weekly prior to and during the IDT meeting. A specific column will be added to the IDT form for monitoring of compliance with the bowel protocol. This monitoring will be ongoing.

1. The bowel treatment protocol was put back on the BM monitoring sheet. (completed 6/23/21)

2. Each resident has been checked to make sure the proper sequence for treatment as outlined in the bowel protocol has been followed. (ongoing)

3. Education given to all nurses at the 7/13/21 staff meeting concerning bowel protocols to be followed beginning the

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F 684	Continued From page 8 interventions to treat constipation until the Fleets enema on 6/19/21. e. On 6/23/21 at 11:57 AM RN #1 stated she tried to give the resident prune juice on day 2 or 3, but the resident spit it out. f. When asked for the facility's bowel management program on 6/23/21 at 11:48 AM, the DON stated they used to have a protocol listed on the BM monitoring form, but somehow it was taken off. She provided a copy of the BM monitoring form with the protocol listed on the bottom of the form. It read "Depending on orders, take these actions. Day 2- Miralax, Prune juice, Senna tablet. Day 3- Dulcolax Suppository. Day 4- Fleets Enema." The DON stated nursing staff should treat for constipation based on what orders the resident had. If there were no orders, the nursing staff should call the physician to get orders.	F 684	third day with no bowel movement based on the bowel protocol and documented as appropriate. (completed) 4. BM chart is reviewed by the DON or designee weekly and recorded in a specific column on the IDT form for monitoring of compliance with the bowel protocol. Ongoing monitoring with no end date. Audits will be done weekly, discussed during the weekly interdisciplinary meeting, and audit results will be reported on the monthly facility-wide QA report and discussed in detail at the Care Center QAPI meeting every other month. (ongoing)	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		7/14/21

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F 880	Continued From page 9	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 10 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, review of immunization documentation, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to ensure social distancing for residents (#11) who were not vaccinated for COVID-19 during 2 of 3 meals observed. The findings were: 1. Observation on 6/21/21 at 5:33 PM revealed resident #11 sat at a table with resident #16 in the dining room during a meal. The residents were not 6 feet apart. 2. Observation on 6/22/21 at 12:49 PM revealed resident #11 and resident #16 again sat at the same table in the dining room during the meal. The residents were not 6 feet apart. 3. The table where the residents were seated was measured on 6/24/21 at 9:25 AM. The table measured 42 inches by 42 inches (3 1/2 feet x 3 1/2 feet). 4. Review of the care plans showed resident #16 had both doses of the COVID-19 vaccine (the second dose was given 2/3/21). However, resident #11 had declined the COVID-19 vaccine.	F 880	F880 Infection Prevention & Control A. Immediate Action: After the DON was informed of residents #11 and #16 being seated too closely together based on one resident not being vaccinated against COVID-19. Prior to the next meal, resident #16 was moved to a table with another resident who had been vaccinated. B. The Potential to Affect Other Residents: No other residents were affected by being seated together in the dining room next to residents who were not fully vaccinated. Any other unvaccinated residents who eat in the dining room have been sitting at tables at least 6 feet away from other residents. C. Systemic Changes: All dining room seating will be monitored to make sure un-vaccinated residents are not seated within 6 feet of vaccinated residents. Staff will be given education during the next staff meeting on 7/13/21 regarding seating arrangements in the dining room that comply with current CDC guidelines.	

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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 880	Continued From page 11 5. Review of the facility's immunization documentation confirmed resident #11 refused the COVID-19 vaccine. 6. During an interview on 6/24/21 at 9:09 AM the DON confirmed the residents were not 6 feet apart and resident #11 was not vaccinated. She stated the residents did well socially together, but the facility would look into options to ensure social distancing for residents who were not vaccinated. 7. Review of "Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination" by the Centers for Disease Control and Prevention (CDC), updated April 27, 2021 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html, accessed 7/2/21) showed "If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others."	F 880	D. How Performance Will Be Monitored: DON or designee will monitor seating arrangements in the dining room weekly and whenever any changes or newly admitted residents are eating in the dining room until CDC guidelines are changed. Audits will be reported on the monthly facility-wide QA report and discussed in the Care Center QAPI meeting every other month. 1. Unvaccinated resident moved to at least 6 feet away from vaccinated resident in the dining room. (completed 6/23/21). 2. Education to staff at the 7/13/21 staff meeting regarding seating arrangements in the dining room that comply with current CDC guidelines. (completed) 3. DON or designee to monitor seating arrangements in the dining room weekly and whenever any changes or new residents are admitted until CDC guidelines change. Monitoring will be ongoing until COVID-19 or any other CDC restrictions are lifted. (ongoing)	