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 _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STAR VALLEY CARE CENTER	130 HOSPITAL LANE AFTON, WY 83110

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/20/22 to 6/23/22. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: ADON: Assistant Director of Nursing DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		7/14/22

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

Electronically Signed | 07/15/2022

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F 623	Continued From page 1	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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F 623	Continued From page 2	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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F 623	Continued From page 3 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written notice of transfer for 1 of 1 sample resident (#13) who was hospitalized. The findings were: 1. Review of nursing notes showed resident #13 was sent to the emergency room on 5/6/22. Further review of nursing notes showed the resident was hospitalized, and returned to the facility on 5/8/22. Review of the medical record showed no evidence of a written transfer notice issued to the resident or family. During an interview on 6/22/22 at 2:48 PM the DON and social services designee both confirmed there was no written notice of transfer.	F 623	F623 Notice Requirement Before Transfer/Discharge A. Immediate Action Taken: For resident #13, we informed the resident and representative that we failed to provide them with a written copy of the transfer form at the resident□s last transfer to the hospital on 5/6/2022. The transfer form was provided in written form to the resident and representative on 7/13/2022 and signed for his hospital stay on 5/6/2022. A copy was sent to the Long-Term Care Ombudsman on 7/13/2022. B. The Potential to Affect Other Residents: All residents transferred or discharged from the facility have the potential to be affected. C. Systemic Changes: A copy of Star Valley Care Center□s Transfer Form was printed and placed in each residents chart with their transfer packet on 6/27/2022. This form is located at the beginning of the transfer packet to alert staff of the need to complete and sign prior to transfer. All staff have been educated on this process at staff meeting on 7/12/2022. An email was provided to staff that were not in attendance on 7/14/2022. D. How Performance Will Be Monitored: The DON, or designee, will perform audits on each transfer for the next 5 transfers. Information from these audits will be presented in the QAPI meetings until substantial compliance has been met.	

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F 623	Continued From page 4	F 623	Continuing education to staff will be provided as deemed necessary.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide notice of the bed-hold policy at the time of transfer for 1 of 1	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer A. Immediate Action Taken: For resident	7/14/22

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F 625	Continued From page 5 sample resident (#13) who was hospitalized. The findings were: 1. Review of nursing notes showed resident #13 was sent to the emergency room on 5/6/22. Further review of nursing notes showed the resident was hospitalized, and returned to the facility on 5/8/22. Review of the medical record showed no evidence notice of the bed-hold policy was provided to the resident or family. During an interview on 6/22/22 at 2:48 PM the DON and social services designee both confirmed there was no evidence the bed-hold notice was provided.	F 625	#13, we informed the resident and representative that we failed to provide them with a written copy of the Bed Hold Policy at the residents last transfer to the hospital on 5/6/2022. The Bed Hold Policy was provided in written form to the resident and representative on 7/13/2022 and signed for his hospital stay on 5/6/2022. B. The Potential to Affect Other Residents: All residents transferred or discharged from the facility have the potential to be affected. C. Systemic Changes: A copy of Star Valley Care Centers Bed Hold Policy was printed and placed in each residents chart with their transfer packet on 6/27/2022. This form is located at the beginning of the transfer packet to alert staff of the need to complete and sign prior to transfer. All staff have been educated on this process at staff meeting on 7/12/2022. An email was provided to staff that were not in attendance on 7/14/2022. D. How Performance Will Be Monitored: The DON, or designee, will perform audits on each transfer for the next 5 transfers. Information from these audits will be presented in the QAPI meetings until substantial compliance has been met. Continuing education to staff will be provided as deemed necessary.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		7/12/22

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F 657	Continued From page 6 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure resident-specific care plans were modified to reflect resident changes for 3 of 15 sample residents (#3, #16, #17) reviewed. The findings were: 1. Review of the 4/8/22 quarterly MDS assessment showed resident #3 was admitted to the facility on 4/16/18 with diagnoses that included multiple sclerosis. Review of the resident's current medical diagnoses showed s/he was diagnosed with dehydration on 5/18/22.	F 657	F657 Care Plan Timing and Revision A. Immediate Action Taken: Care plan for resident #3 was updated on 6/23/2022 to include both the hydration diagnosis as well as comfort care measures. Care plan for resident # 16 was updated to include catheter as a problem area including type, cares interventions and maintenance on 6/23/2022. Bed alarm for resident #17 was removed on 6/22/2022 by the DON. B. The Potential to Affect Other Residents: All residents care plans have	

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F 657	Continued From page 7 Review of a nursing note dated 5/23/22 at 12:51 PM showed the physician wanted to " ... place [the resident] on comfort measures as of today ..." Review of current physician orders showed a 5/23/22 order for comfort measures. The following concerns were identified: a. Review of the current care plan, last revised 6/20/22, showed no documentation related to the hydration diagnosis, or the implemented comfort care measures. 2. Review of the 3/25/22 quarterly MDS assessment showed resident #16 was admitted to the facility on 9/15/21 with diagnoses that included neurogenic bladder, postoperative urinary retention, acute renal insufficiency, and sepsis due to urinary tract infection. The following concerns were identified: a. Review of the current care plan, last revised 10/5/21, showed the plan did not address the catheter as a problem area, and did not contain documentation related to type, cares, interventions, or maintenance. 3. Review of the 5/10/22 quarterly MDS assessment showed resident #17 was admitted to the facility on 12/12/21 with diagnoses that included anxiety, bilateral leg pain, chronic pain, poor mobility, weakness, neuropathy, and frequent falls. Review of a nursing progress note from 3/31/22 at 4:56 AM showed " ... Bed alarm/chime in place for safety ..." The following concerns were identified: a. Review of the current care plan, last revised 6/9/22, identified a problem area of the resident being at high risk for falls. However, further review showed no documentation related to the use of a bed alarm as an intervention.	F 657	the potential to be affected by the timing and revision of new interventions. C. Systemic Changes: Education was given to all staff on 7/12/2022 concerning applicable changes to residents plan of care. All care plans have been reviewed for relevant diagnoses per MDS triggers, comfort care measures, catheter compliance, and fall interventions as applicable by the MDS coordinator. D. How Performance Will Be Monitored: Each week in IDT, residents care plans and/or CASPER triggers, will be reviewed to ensure timely and appropriate interventions have been implemented for the next month. During the review, the IDT team will ensure relevant diagnoses per MDS triggers, comfort care measures, catheter compliance, and fall interventions as applicable. Information from these audits will be presented in the QAPI meetings until substantial compliance has been met.	

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F 657	Continued From page 8 4. Interview with the facility administrator and DON on 6/23/22 at 11:28 AM confirmed the care plan components for these residents " ... were lacking ..." Further, they were aware of issues surrounding care planning and updates, and were hoping the new electronic medical records system they will be implementing will assist with timeliness and updates. 5. Review of facility policy "Interdisciplinary Care Planning", effective 7/2020, showed "Procedure: ... each trigger needs to be care planned as well as other items as needed ... Each resident's care plan will be updated quarterly and as needed ..."	F 657		
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 observation, medical record review, and resident and staff interview, the facility failed to provide care and services in accordance with physician's orders for 1 of 2 sample residents (#5) with non-pressure ulcer skin issues. The findings were: 1. Review of the 12/28/21 significant change MDS assessment showed resident #5 had 5 venous and/or arterial ulcers. The pressure ulcer	F 684	F684 Quality of Care A. Immediate Action: Orders for wound care for resident #5 were clarified with the provider on 6/23/2022 and a written order was received on 6/29/2022. Wound care interventions per provider orders were implemented on 6/29/2022. B. The Potential to Affect Other Residents: All residents receiving wound care treatment have the potential to be	7/12/22

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F 684	Continued From page 9 care area assessment (CAA) for the 12/28/21 MDS assessment showed the resident had chronic venous stasis dermatitis. Review of the 3/30/22 quarterly MDS assessment showed the resident had no venous or arterial ulcers. Review of physician orders showed a current order for wound care dated 1/8/20 which read "Discontinue unna boot. Betadine diluted with sterile NS [normal saline] dampened gauze to open wounds bilateral lower extremities. Then apply kerlix. Then coban. Dressing changes QOD [every other day] starting today." The following concerns were identified: a. Observation on 6/22/22 at 4:08 PM showed the resident ambulating in the hall. S/he was noted to have tan dressings on his/her lower legs that extended from just above the ankle to just below the knee on both legs. It was noted the dressings were marked with the date "6/13." Interview with RN #1 at that time revealed the dressings were now changed every 7-10 days. She further stated nursing staff used to change them every 3 days. b. Review of a nursing note dated 10/7/21 showed "Dressings to legs now changed once weekly per Dr [physician last name]." However, further review of physician orders showed no such order. c. Review of wound care documentation from 5/1/22 to 6/23/22 showed wound care was documented as provided on 5/14/22, 5/25/22, 6/6/22 and 6/13/22. d. Observation on 6/22/22 at 4:20 PM of care and dressing changes to the resident's lower legs showed RN #1 prepared a solution of Betadine diluted with normal saline. Observation of the left lower leg showed a bruising discoloration covering the area where the dressing used to be, along with a few small scabs. Observation of the	F 684	affected. C. Systemic Changes: Education on receiving a physician order and the proper process for order entry was provided to all nurses on 7/12/2022. Education on documenting of wound treatments was also completed on 7/12/2022. All charts of residents receiving wound care were reviewed for proper orders and charting on 6/28/2022. D. How Performance Will Be Monitored: Wound care orders and charting will be reviewed weekly by the DON or designee and reported during IDT for the next month. Information from these audits will be presented in the QAPI meetings until substantial compliance has been met.	

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right lower leg showed the same bruising discoloration where the dressing had been, along with a large area of tan discoloration and scabbing on the outside of the calf just below his/her knee, as well as to the front of the shin. No open wounds were observed at that time. Both lower legs were then cleansed with the Betadine solution and lotion was applied. Pieces of gauze were soaked in the Betadine solution and applied to the tan areas below the knee and on the shin of the right lower leg, as well as covering the scabbed areas to the left lower leg. Both lower legs were then wrapped in gauze wrap, then covered with Kerlix wrap.

e. During a phone interview on 6/23/22 at 9:03 AM the resident's physician stated the resident had a long history of stasis dermatitis on his/her lower legs. She stated the current care for the resident's legs was washing the legs in the shower and wrapping with Coban and Kerlix. When asked about the Betadine solution, she stated that was "...back when [his/her] legs were in flared up state..." and was not the current treatment as far as she knew. She stated the frequency of dressing changes should be weekly.

f. During an interview on 6/23/22 at 9:18 AM the DON confirmed that the documentation did not show weekly wound care.