STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star Valley Care Center	**130 Hospital Lane , Afton, Wyoming, 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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/9/26 through 2/12/26. Also reviewed in the course of the survey was complaint intake 2705015. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NA: nurse aide RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		03/03/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: This requirement was not met as evidenced by:	F0689	F0689: Free of Accident Hazards/Supervision/Devices A). Immediate Action Taken: On 2/12/2026, all staff on duty were informed that when lifting or lowering a patient supported by a sling in the Maxi Move mechanical Hoyer lift, the castor brakes are not to be used. This ensures the lift can move appropriately and align with the patient's center of gravity. B). The Potential to Affect Other Residents: The facility has determined that any resident requiring the use of a Hoyer lift could potentially be affected by this practice. C). Systemic Changes: Education was provided on 2/12/2026 to all staff members who operate the Maxi Move mechanical Hoyer lift. A follow-up email was sent on 2/13/2026 by the Director of Nursing reinforcing the education. The training emphasized that castor brakes should not be used when lifting or lowering a patient	03/03/2026

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 reverse for further 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.

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

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F0689 SS = D	Continued from page 1 Based on observation, staff interview and review of the manufacturer instructions, the facility failed to ensure resident safety for 1 of 3 residents reviewed for mechanical hoyer lift transfers (#8). The findings were: 1. Review of the quarterly MDS assessment dated 1/7/26 showed resident #8 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment and had diagnoses which included neurogenic bladder, multiple sclerosis, and cancer. Further review showed the resident was wheelchair dependent, relied on staff for ADL cares, and required the use of a mechanical lift for transfers. The following concerns were identified: a. Observation on 2/11/26 at 10 AM showed NA #1, and CNA #1 had locked the mechanical hoyer lift (Maxie Move) wheels while the resident was raised out of his/her wheelchair. The hoyer wheels were then unlocked when the resident was moved and positioned over the bed. The wheels were then locked again as the resident was lowered to the bed. b. Observation on 2/11/26 at 3:59 PM showed CNA #2 and CNA #3 had locked the mechanical hoyer lift wheels while resident #8 was raised from his/her bed and while s/he was lowered into the wheelchair. 2. Interview with CNA # 3 on 2/11/26 at 4:46 PM revealed hoyer wheels were always locked when raising or lowering residents. 3. Review of the Maxi Move mechanical hoyer lift manual showed…"when lifting or lowering a patient who is supported by a sling, do not use the castor brakes. This allows the lift to move to the correct position using the patient's center of gravity."	F0689	Continued from page 1 supported by a sling, as the lift must be able to move freely to properly align with the patient's center of gravity. The policy "Mechanical Lift Use" was updated to reflect the verbiage above and sent to the QAPI team on 2/27/2026. D). How Performance will be Monitored: Direct observation of staff operating the Maxi Move mechanical Hoyer lift will occur weekly for one month, followed by monthly observations for six months, or until substantial compliance is achieved. Observations and findings will be documented on a monitoring form, and results will be presented at QAPI meetings during the monitoring period.	
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	F0761 Label/Store Drugs and Biologicals A). Immediate Action Taken: The expired Cyclobenzaprine hydrochloride tablets were removed from the medication cart and properly disposed of on 2/11/2026. The expired glucose tablets were removed from the medication cart and properly disposed of on 2/12/2026. The expired tramadol was removed from the medication cabinet and properly disposed of on 2/11/2026. The expired Lispro insulin was removed from the medication cart and properly disposed of on 2/26/2026. B). The Potential to Affect Other Residents: The facility has determined that all residents with medication orders have the potential to be affected by this practice.	02/26/2026

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F0761 SS = E	Continued from page 2 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, manufacturer's instructions and policy and procedure review the facility failed to ensure residents had access to unexpired medications in 2 of 2 medication storage areas (medication cart, medication room). The findings were: 1. Observation of the facility medication cart on 2/11/26 at 10:12 AM showed a Lispro insulin pen 100 units/ milliliters with a manufacturer expiration date of 1/28. The pen was labeled with resident #7's name, the date it was opened on 12/30/25 and had approximately 190 Units out of 300 units remaining. Review of the manufacturer's instructions titled "Instructions for Use - Insulin Lispro" last revised 7/2023 showed "Do not use your pen past the expiration date printed on the label or for more than 28 days after you first start using the Pen." Interview with RN #1 revealed resident # 7 had received doses of the Lispro insulin 28 days after opening. 2. Observation of the facility medication cart on 2/11/26 at 10:13 AM showed a bottle of glucose tablets (Lot # 45683) with no open date, and no visible expiration date. The bottle was 1/4 to 1/2 full. Interview with RN #1 revealed the medication was a community bottle and was available for resident use. 3. Observation of the facility medication cart on 2/11/26 at 10:15 AM showed Cyclobenzaprine hydrochloride 5 milligrams (mg) tablet 1 tablet three times daily as needed with an expiration date of 10/31/2025 and labeled with resident #11's name. Further observation showed 6 pills were missing from the medication card. Per RN #1 the card was brought with the patient upon admission and was available for	F0761	Continued from page 2 C). Systemic Changes: Education was provided to all nursing and pharmacy staff on 2/26/2026 regarding medication outdating responsibilities, management of multi-dose medications, and the newly approved policy. In-person training from pharmacy will also be conducted at the 3/10/2026 team meeting to reinforce these practices. A new policy titled “Medication Management Upon Admission to Star Valley Care Center” was created and approved at QAPI on 2/18/2026. This policy addresses the handling of medications received from outside facilities, as several of the expired medications identified fell into this category. The policy “Outdated or Expired Medications” was updated on 2/26/2026 to reflect the following; 1). Language was added to clarify that Pharmacy will manage the outdates within the medication room, and the medication cart. Nurses will be responsible for checking outdates within the individual patient rooms, if applicable. 2). Language was added to clarify that medication without an expiration date will be quarantined. Pharmacy will contact the manufacturer or distributor for written confirmation of expiation dating. Items for which dating cannot be verified will be returned or destroyed. Starting on 2/26/2026, pharmacy began affixing labels for RNs to be able to mark the date opened and BUD for applicable medications. D). How Performance will be Monitored: An audit will be conducted monthly for six months, or until substantial compliance is achieved. The audit will be completed by Pharmacy and will include verification that no expired medications are present in medication carts or medication cabinets. Results will be documented on the audit form and reviewed by both Pharmacy and Nursing. Audit findings will also be reported to the QAPI team during the monitoring period.	

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F0761 SS = E	Continued from page 3 patient use. 4. Observation of the locked medication cabinet in the medication room on 2/11/26 at 10:22 AM showed tramadol 50 mg tablet 1 tablet every 8 hours as needed. The medication was labeled with an expiration date of 10/25 and with resident #11's name. Interview with RN #1 on 2/11/26 at 10:23 AM revealed the resident brought the card with her upon admission and it was available for patient use. 5. Interview with RN #2 on 2/11/26 at 10:24 AM revealed nursing staff periodically checked for medication expiration dates and the pharmacy staff checked for and disposed of expired medication monthly. 6. Interview with pharmacy technician #1 on 2/11/26 at 11:29 AM revealed medication storage was checked monthly and outdated medications were removed and destroyed. She further revealed the most recent check was performed on 2/10/26. 7. Interview with the DON on 2/11/26 at 11:58 AM confirmed the pharmacy staff audit medication storage monthly and expired medication should have been removed and returned to the pharmacy. 8. Review of the policy titled "Outdated or Expired Mediations" showed....1. "Expiration dates for all medications shall be upon the package."....2. "Pharmacy will be responsible for monthly inspections."	F0761		
F0880 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	F0880	F0880 Infection Prevention and Control A). Immediate Action Taken: On 2/16/2026, the employee observed was re-educated by the Quality and Education Coordinator on the importance of changing gloves during resident care when moving from a contaminated body site to a clean body site or when transitioning to different areas of the room. B). The Potential to Affect Other Residents: The facility has determined that all residents have the potential to be affected by this practice. C). Systemic Changes: Education was provided to staff on 2/12/2026 by the Infection Preventionist regarding the Hand Hygiene policy, including the importance of changing gloves when moving from a contaminated body site to a clean body site. A follow-up email reinforcing this education was sent by the Director of Nursing on 2/13/2026. D). How Performance will be Monitored: Hand hygiene	03/03/2026

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F0880 SS = D	Continued from page 4 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 §483.71 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 4 observations will be conducted weekly for one month by the Infection Preventionist, followed by monthly observations for six months, or until substantial compliance is achieved. Results will be documented on the audit form, reviewed with the nursing team, and presented at QAPI meetings during the monitoring period.	

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F0880 SS = D	Continued from page 5 §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, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 12 sampled residents (#8) reviewed. The findings were: 1.Review of the quarterly MDS assessment dated 1/7/26 showed resident #8 had a BIMS score of 12 out of 15, which indicated moderate cognitive impairment and had diagnoses which included neurogenic bladder, multiple sclerosis, and cancer. Further review showed the resident was wheelchair dependent and relied on staff for ADL cares. The following concerns were identified: a. Observation on 2/11/26 at 10 AM showed NA #1 provided a brief change and peri care to resident #8. Further observation showed NA #1 wore the same gloves while she retrieved a new package of personal cleansing wipes from the resident's closet. She placed a new brief under the resident and rolled him/her on to his/her back without changing gloves. Observation at 10:26 AM showed the soiled gloves were removed, hand hygiene was performed, and new gloves were applied. The resident was then fully dressed. b. Interview with the infection preventionist on 2/11/26 at 1:30 PM revealed staff should have practiced hand hygiene and changed gloves after contact with the soiled body area, and prior to moving to a clean area. 2. Review of the facility policy and procedure titled “Hand Hygiene (Handwashing) policy”, last revised 2/2025 showed….1. Hand washing is required: i.3. After potential or actual body fluid exposure, i.5. Before moving from a soiled body area to a clean body area on the same patient, and….10. Change gloves during patient/resident care if moving from a contaminated body site to a clean body site."	F0880		