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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Star Valley Care Center	130 Hospital Lane Afton, WY 83110

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This requirement was not met as evidenced by: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 [DATE] 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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.