DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

(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 The following common abbreviations are used throughout this document: CAA- Care Area Assessment CNA- certified nursing assistant DON- director of nursing LPN- licensed practical nurse MDS- Minimum Data Set RN- registered nurse Less commonly used abbreviations will be annotated in each deficiency where used.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assess 2 of 3 sample residents (#6, #33) reviewed for self-administration of medications. The findings were: 1. Observation of medication pass in the secure unit on 11/29/11 at 7:38 AM showed RN #1 left the medication Aricept 5 milligrams (mg) on the dining table for resident #33. Review of the medical record showed no evidence an assessment for self administration of medications was performed. In addition, review of the medical record showed there was no physician's order to	F 176	The facility will ensure that residents are not allowed to self-administer medication unless a physician order and assessment are present to determine that resident's ability to self-administer medications. A) All residents in the facility including residents #6 and #33 will not be allowed to self-administer medications. B) Education will be provided to nursing regarding the medication self-administration policy.	12/30/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rich Schrenk | TITLE: CEO/LNHA | (X6) DATE: 1-24-12

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.

The POC was accepted with additions. Facility was notified. Corrections/additions were reviewed with Traci Harrison DON on 1/27/12 at 1:45 pm by Kathryn Moyer State Surveyor

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F 176	Continued From page 1 self administer any medications. Interview with RN #1 on 11/30/11 at 3:10 PM confirmed an assessment for self administration of medications was not performed for this resident. Additionally, she verified there was no physician's order for this resident to self administer medications. 2. Observation of medication pass in the secure unit on 11/29/11 at 7:39 AM revealed RN #1 left a medicine cup containing aspirin 81 mg, Diovan 160 mg (anti-hypertensive), Lopid 600 mg (anti-hyperlipidemic), and Metformin 500 mg (diabetes) at the dining table for resident #6. Review of the medical record showed no physician's orders to self administer these medications. Also, further review showed no evidence an assessment of the resident's ability to self administer medications was performed by the treatment team. Interview with RN #1 on 11/30/11 at 3:10 PM confirmed an assessment for self administration of medications was not performed for this resident and there was no physician's order to self administer medications. 3. Interview with RN #1 on 11/29/11 at 7:50 AM revealed she always left medications on the dining table for these two residents (#6, #33) because she could count on them to take the medications. Interview with the DON on 11/30/11 at 1:15 PM revealed the facility basically did not allow self administration of medications, but if they did, they would use their pharmacy's policy.	F 176	C) Monitoring of compliance of nursing staff will be done by weekly random observation of medication administration by supervisors using the quality improvement monitoring tool until the ~~next state survey~~ until substantial compliance has been met. KR D) Nurses not following the medication self-administration policy will be educated by the supervisor and corrective actions will be taken. E) Results will be reported quarterly at the Quality meeting as part of the facility Quality Assurance Program.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248	The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. KR	12/30/11

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F 248	Continued From page 2 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure 2 of 9 sample residents (#16, #30) who were reviewed for activities received an ongoing program of activities during all days of the survey. The findings were: 1. Review of the 9/9/11 significant change MDS assessment showed resident #16 triggered for a problem in activities. Review of this MDS assessment showed the resident enjoyed music. Review of the initial activities assessment completed on 8/3/10 showed the resident was interested in gardening and plants, wood carving, and dogs. Review of the 9/13/11 CAA showed the resident had dementia and had declined in condition which resulted in reduced activity participation at times. Review of the 9/13/11 care plan showed a goal of participation in two to three activities per week with interventions including encouraging the resident to attend activities of choice, providing a calendar of activities, assisting the resident to and from activities, and anticipating the resident's needs. The following concerns were identified: a. Observation on 11/29/11 from 7:15 AM through 11:07 AM showed the resident was not invited to or encouraged to attend any of the activities during that time which included having his/her hair done, music on a CD, TV, or kick ball. b. Observation on 11/30/11 from 12:30 PM through 3 PM showed the resident was not invited	F 248	A) The facility will ensure that all residents will receive an Activities Assessment to ensure that their activity needs are met. Resident #16 is deceased. Resident #30 is currently being invited to all planned activities. Care Plan was updated December 28, 2011. B) Random rounds and two chart reviews will be done weekly using the activity quality improvement tool until the ~~next state survey~~ until substantial compliance has been met by Activity Director to ensure all residents are invited to all planned activities. Activities planned for individual residents will be modified to meet each resident's needs per activity assessment/MDS interview. Documentation for activity attendance for all individual residents will be completed daily to ensure activity needs are being met. Activity staff members will counseled immediately if their charting is not completed and that residents were not asked to attend. C) All Activity staff will be educated on charting requirements to include whether resident declined or accepted invitation, if encouragement was needed, and level of participation of 1:1 activities. Activity staff not inviting all residents to a planned activity will be given immediate in-servicing and corrective actions will be taken. Activity calendars will be reviewed monthly by activity staff. Additions or changes will then be made to their care plans as necessary. Residents with changes in activity needs will have their care plans reviewed quarterly with their MDS or more often if needed. D) A quality assurance program will be set up through the Activity Department to monitor residents' attendance at planned activities and ensure their current care plan is effective for each resident. Residents will be checked quarterly or more often if they have had a change. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	12/30/12

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F 248	Continued From page 3 or encouraged to participate in any activity during that time, including a musical presentation held in the secure unit. c. Interview with the activity aide on 11/30/11 at 1:32 PM revealed this resident had declined and due to the dementia, was sometimes agitated and combative. The activity aide verified a more individualized approach would be beneficial to the resident. 2. Review of the 8/26/11 annual MDS assessment for resident #30 showed s/he triggered for a problem in activities. Review of this MDS assessment showed the following activities were very important: listening to music, going outside to get fresh air, and participating in religious services. Review of the 11/22/11 care plan showed a goal for the resident to attend one to two activities per week. Interventions listed on the care plan included: encourage and assist the resident to activities, provide the resident a calendar of events, and anticipate the resident's needs. The following concerns were identified: a. Observation on 11/29/11 from 7:15 AM through 11:07 AM showed the resident was not invited to or encouraged to attend any of the activities during that time which included having his/her hair done, music on a CD, TV, or kick ball. b. Observation on 11/30/11 from 12:30 PM through 3 PM showed the resident was not invited or encouraged to participate in any activity during that time, including a musical presentation held in the secure unit. c. Interview with the activity aide on 11/30/11 at 1:32 PM revealed this resident had declined and due to the dementia had a loss of interest in activities and wanted to sleep most of the day. The activity aide also said this resident received	F 248		

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F 248	Continued From page 4 one to one visits. However, review of activity records showed no evidence the resident's level of participation in the one to one visits or the effectiveness of the visits was assessed.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care plans were developed in a variety of areas for 2 of 13 sample residents (#62, #75). The findings were: 1. Medical record review for resident #62 showed	F 279	The facility will ensure a comprehensive care plan will be developed within seven days after completion of the comprehensive quarterly assessment, prepared by the Inter Disciplinary Team (IDT), and periodically reviewed and revised by a team of qualified persons after each assessment and as needed. A) Care plans will be reviewed and updated by the IDT quarterly following the MDS. Care plans will be updated for resident #62 and #75 and all other residents daily as needed by staff. B) All staff will be educated on care plan requirements.	12/30/11

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F 279	Continued From page 5 s/he had diagnoses to include diabetes, generalized weakness, urinary retention and morbid obesity. The following concerns were identified: a. Observation on 11/29/11 at 9:10 AM showed the resident had a foley catheter draining yellow urine. Review of the physician orders dated 11/8/11 showed the resident had a foley catheter for urinary retention which was to be changed every month. Review of the 11/11/11 annual MDS assessment showed the resident had an indwelling catheter and the 11/15/11 CAA for urinary incontinence and indwelling catheter showed because of the resident's restricted mobility, the urinary catheter needed to be addressed in the care plan. Review of the care plan last dated 11/15/11 showed the indwelling catheter was not addressed. b. Observation on 11/29/11 at 9:45 AM showed CNA #1 inspected skin folds and applied Desitin ointment (used to protect skin from irritants/moisture) to the resident's skin. A small open area was found and reported to the nurse. Review of the physician orders dated 11/8/11 showed the resident was to have zinc oxide topical ointment (Desitin) applied twice daily to his/her perineum and under the abdominal folds. Review of the 11/11/11 annual MDS assessment, section V, showed a care plan for pressure sores was to be developed. Review of the care plan last dated 11/15/11 showed there was no plan of care for pressure ulcers or the prevention of skin breakdown. 2. Medical record review for resident #75 showed s/he had diagnoses to include dementia and anxiety. The following concerns were identified: a. Review of the admission physician orders	F 279	C) Compliance will be monitored using the quality improvement tool by weekly rounds by nurse supervisor to compare changes to 24 hour sheets to ensure care plan was updated until ~~the next state survey~~. substantial compliance has been met. KK D) Staff identified not updating care plans will be given immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance programs.	

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F 279	Continued From page 6 dated 9/29/11 showed s/he had an order for alprazolam (for anxiety) 0.25 milligrams (mg), 1/2 tablet as needed daily. Review of the physician orders dated 10/28/11 showed the medication frequency was increased to 3 times daily as needed. Review of the 10/7/11 admission MDS assessment, section V, showed a care plan for psychotropic drug use should be developed. Review of the care plan last dated 10/11/11 showed there was not a plan of care developed for the psychotropic medication alprazolam. b. Review of the 10/7/11 CAA for falls showed the resident had impaired balance during transfers and a care plan was to be developed. Review of the care plan last dated 10/11/11 showed there was not a plan of care for falls. 3. During an interview with the MDS coordinator on 12/1/11 at 8:10 AM, she verified that care plans were not developed for indwelling catheters or pressure ulcers for resident #62. She also acknowledged a care plan had not been developed for resident #75 related to psychotropic drug use.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	The facility will ensure that the residents and/or family have an opportunity to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan will be developed within seven days after the completion of the comprehensive assessment, prepared by an IDT, that includes the attending physician, a	12/31/11

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F 280	Continued From page 7 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident care plans were updated to accurately reflect current interventions for 2 of 13 sample residents (#14, #16). The findings were: 1. Review of the medical record for resident #16 showed s/he had diagnoses including MRSA (Methicillin Resistant Staphylococcus Aureus) of the left ankle surgical wound. Interview with the wound care nurse on 11/29/11 at 11:07 AM revealed the resident was on contact precautions. However, review of the care plan dated 9/13/11 showed it was not updated to reflect the contact precautions for MRSA or that MRSA was even present in the wound. Interview with RN #1 on 11/29/11 at 3:10 PM verified the MRSA and contact precautions was not added to the care plan. 2. Review of the medical record for resident #14 showed s/he had diagnoses which included cerebral vascular accident with left sided weakness. Review of the care plan showed an undated plan for "Grasshopper brace for fingers" with functional limitations due to "Contractures in	F 280	RN with responsibility for the resident and other appropriate staff in disciplines determined by the residents' needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative and periodically reviewed and revised by a team of qualified persons after each assessment. A) Care plans will be reviewed and updated by the IDT quarterly following the MDS, and daily as needed by the charge nurse until ~~the next state survey.~~ until substantial compliance has been met. KR B) Residents #14 and #16 are deceased. C) Care plan will be reviewed and updated if needed by the physician quarterly.	

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F 280	Continued From page 8 fingers." The following concerns were noted: a. During periodic observations from 11/28/11 through 12/1/11, the resident had bilateral hand contractures without the aid of splints or other devices. When staff were present, they did not ask the resident if s/he wanted hand splints, and the resident never spoke unless spoken to. b. Review of a 11/16/11 physician's progress note showed the following, "[The resident] states that [his/her] wrists are bothering [him/her] more without the splints and would like them back on." The plan on the progress note stated that the resident may use his/her wrist splint. c. Interview with the DON and resident's family member on 11/30/11 at 1:15 PM revealed the resident should be asked by staff if s/he would like hand splints. Both the DON and the resident's family member confirmed that the care plan should be updated to require staff to ask the resident his/her preference concerning the use of hand splints for comfort.	F 280	D) Residents and/or legal representative will be invited quarterly and PRN to attend care plan meetings with the IDT. E) Compliance will be monitored by rounds by nurse supervisor. and documented on the weekly QI round sheet RW 1) Weekly to compare changes on 24 hour sheet to ensure the care plan is updated until the next state survey. 2) Quarterly care plan review to ensure care plans are reviewed and updated if needed by the providers. 3) Quarterly care plan letters will be sent to the resident and/or legal representative to invite them to attend and participate. Ward clerk will keep a log of letters sent and who participated in the care planning meeting. 4) Section V will be reviewed and compared to care plan prior to MDS completion by the MDS Coordinator. F) Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 13 sample residents (#16, #22). The findings were:	F 282		

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F 282	Continued From page 9 1. Review of the individualized bowel and bladder plan (dated 11/3/11) and the 11/8/11 care plan revealed staff were instructed to assist resident #22 to the toilet every two hours, before and after meals, and as needed. However, observation on 11/29/11 from 8:31 AM until 12:35 PM (4 hours 4 minutes) revealed the resident was not offered nor taken to the toilet, which included before the lunch meal. During an interview at 12:35 PM, after assisting the resident to the toilet, CNA #2 stated she was not sure when the resident was last assisted to the toilet. She stated she bounced back and forth from other units, therefore she did not know. On 11/30/11 at 4:15 PM, the RN responsible for the toileting plans stated the care plan was current and should have been followed by staff. She further stated "...Four hours is frankly too long." 2. Observation on 11/29/11 from 7:15 AM through 10:47 AM (3 hours 32 minutes) revealed resident #16 was not toileted. At 10:47 AM, the resident was taken to the bathroom for a shower where s/he was found to have a wet incontinence brief. Review of the 9/13/11 care plan showed the resident should be toileted after meals and every two to three hours. Interview with CNA #3 on 11/29/11 at 10:26 AM revealed the resident should be toileted every two to three hours.	F 282	The facility will ensure services will be provided by qualified persons in accordance with each resident's written plan of care. A) Education will be provided to all staff regarding toileting residents according to their bowel and bladder plans. If staff are not toileting according to bowel and bladder plans, immediate in-servicing and corrective actions will be taken. B) Resident #16 is deceased. C) Resident #22 will be assisted to the toilet every two hours, before and after meals, and as needed, as stated on the bowel and bladder plan. D) Staff will follow bowel and bladder plans for all residents. E) Compliance of staff will be monitored by random observation of residents weekly by a nurse supervisor until ~~the next state survey~~. substantial compliance has been met and documented on the weekly QI round sheet. LR F) Results will be reported quarterly as part of the facility Quality Assurance Program.	12/30/11
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff interview and review of policies and procedures, the facility failed to ensure appropriate perineal care was provided for 2 of 5 sample residents (#7, #16) observed who required such care. The findings were: 1. Observation on 11/30/11 at 12:45 PM showed CNA #4 failed to cleanse resident #7's anterior perineum after s/he was found to be incontinent of urine. The CNA cleansed the resident's posterior perineum then reached between his/her legs and partially cleaned the anterior perineum. However, the skin of the abdomen and upper thighs were not cleansed. Review of the 9/23/11 quarterly MDS assessment showed the resident required extensive assistance with personal hygiene and toileting. Interview with the CNA immediately following the observation acknowledged all skin that comes in contact with urine needed to be cleansed. 2. Review of the 9/9/11 significant change MDS assessment for resident #16 showed s/he was always incontinent of bowel and bladder. Further review showed the resident required extensive staff assistance with personal hygiene. Observation on 11/30/11 at 1 PM showed CNA #5 assisted the resident to bed to change the resident's wet incontinence brief. Observation showed the CNA did not cleanse the buttocks or anterior perineal area which had been in contact with the wet incontinence brief. Interview with the CNA at the time revealed she was taught to clean all areas of the body that were in contact with the	F 312	The facility will ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal hygiene. A) Education will be provided to all staff regarding providing appropriate pericare to all residents according to facility policy. Staff observed not providing appropriate pericare will be given immediate in-servicing and corrective actions will be taken. B) Appropriate pericare will be provided for resident #7, and resident #16 is deceased. C) Staff will provide all residents with appropriate perineal care. D) Compliance of staff will be monitored by random observation of residents weekly by the nurse supervisor until ~~the next state survey~~. documented on the weekly QI round sheet. KR E) Results will be reported quarterly as part of the facility Quality Assurance Program. substantial compliance has been met. KR	

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F 312	Continued From page 11 wet incontinence brief. 3. Review of the facility's policy on perineal care, revised January 2002, showed instructions to "Continue to wash the perineum....including thighs...wash the rectal area thoroughly..."	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide appropriate care to promote dryness for 1 of 10 sample residents (#16) with urinary incontinence. In addition, the facility failed to ensure staff provided appropriate catheter care for 1 of 2 sample residents (#62) who had urinary catheters. The findings were: 1. Review of the 9/9/11 significant change MDS assessment for resident #16 showed s/he was always incontinent of bowel and bladder. Further review showed the resident required extensive staff assistance with personal hygiene. Observation on 11/29/11 from 7:15 AM through	F 315	The facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. A) Resident #16 is deceased. B) All residents including resident #62 will receive appropriate catheter care, including appropriate placement of urinary catheter bags. C) Education will be provided to all staff regarding following residents bowel and bladder plans and appropriate urinary catheter care procedures, including appropriate placement of urinary catheter bags. Staff not following corrective procedures will receive immediate in-servicing and corrective actions will be taken.	12/30/11

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F 315	Continued From page 12 10:47 AM (3 hours 32 minutes) revealed the resident was not toileted during that time. At 10:47 AM, the resident was taken to the bathroom for a shower where s/he was found to have a wet incontinence brief. Review of the 9/13/11 care plan showed the resident should be toileted after meals and every two to three hours. Interview with CNA #3 on 11/29/11 at 10:26 AM revealed the resident should be toileted every two to three hours. Interview with RN #1 on 11/30/11 at 3:10 PM verified the resident should have been toileted after breakfast on 11/29/11 and should have been toileted every two to three hours between meals. 2. Review of the medical record for resident #62 showed s/he had diagnoses to include urinary retention and BPH (enlarged prostate). The physician admission orders dated 8/8/11 showed the resident had a foley catheter for urinary retention. The following concerns were identified: a. Observation on 11/29/11 at 10 AM showed CNA #1 placed the foley bag on the top bar of his/her walker during transfer to the bathroom. The foley bag was above the resident's bladder which did not allow it to drain. After the resident was positioned on the toilet, the CNA then placed the catheter bag on the floor. b. Observation on 11/30/11 at 11 AM showed the resident's foley catheter bag was placed above his/her bladder while on the stationary bicycle in the restorative work-out area. After seven minutes of observation, restorative staff member #1 placed the bag below the level of the bladder. c. Review of the policy and procedure for urinary catheter care (No. 4128) last revised 11/11/11 stated the the urinary drainage bag	F 315	D) Compliance of staff will be monitored by weekly random rounds observing foley catheter bag placement and toileting schedules by supervisors until ~~the next~~ on the weekly QI round sheet and documented ~~state survey~~. substantial compliance has been met. klo E) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 315	Continued From page 13 must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. d. Interview with the infection control nurse on 11/30/11 at 2:30 PM acknowledged the foley catheter bag needed to be placed below the bladder for proper drainage.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure a safe environment for 1 of 4 nursing units (secure unit with a census of 17 residents). The findings were: Observation of medication pass in the secure unit on 11/29/11 at 7:38 AM showed RN #1 left the medication Aricept 5 milligrams (mg) on the dining table for resident #33. Seated next to resident #33 was another resident on the secure unit. At 7:39 AM on the same day the RN left a medicine cup containing aspirin 81 mg, Diovan 160 mg (anti-hypertensive), Lopid 600 mg (anti-hyperlipidemic), and Metformin 500 mg (diabetes) at the dining table for resident #6.	F 323	The facility will ensure that the resident environment will remain as free of accident hazards as possible and that each resident receives adequate supervision to prevent accidents. A) No medication will be left unattended by nursing on all units including the secure unit. B) Charge nurse will be educated on the importance of not leaving medications unattended to ensure safety of the residents. C) Monitoring of compliance of nursing will be done weekly by random rounds of and document on the weekly QA round sheet. KC the nurse supervisor until ~~the next state survey.~~ substantial compliance has been met. KC Nurses leaving medications unattended will receive immediate in-servicing and corrective actions will be taken.	12/30/11

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F 323	Continued From page 14 Another secure unit resident was seated directly across from resident #6 at that time. Interview with the RN at 7:50 AM on 11/29/11 revealed she routinely left medications for residents #6 and #33 on the table because she could depend on those residents taking their medications. When asked how she could ensure other residents with dementia seated at the same tables would not take the medications by mistake, the RN said there was always a staff member at the tables when she passed medications. However, observation on 11/29/11 at the times noted previously showed no staff were at the tables or in the vicinity of the dining tables to ensure the safety of all residents in the secure unit.	F 323	D) Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure adequate interventions were implemented related to hydration for 1 of 3 sample residents (#16) who had dehydration identified as a problem. The findings were: Review of the 9/9/11 significant change MDS assessment for resident #16 showed s/he required total dependence with eating and one person physical assist. Continued review of the MDS showed the resident experienced dehydration. Review of the 9/13/11 CAA showed	F 327	The facility will provide each resident with sufficient fluid intake to maintain proper hydration and health. A) Resident #16 is deceased. B) All residents will receive adequate interventions related to hydration.	12/30/11

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F 327	Continued From page 15 the resident had laboratory (hemoglobin and hematocrit) findings on 8/29/11 indicating dehydration. Review of the 9/13/11 CAA for dehydration showed the resident had inadequate fluids due to his/her dementia with fluid intake of less than 1000 cc (cubic centimeters) per day. Review of the registered dietitian's notes dated 11/22/11 showed the resident should be offered 950 cc or more of fluids per day and should have 360 cc of fluids with each meal. The following concerns were identified: a. Observation on 11/29/11 from 7:15 AM through 11:07 AM (almost four hours) showed no staff offered or provided the resident with any fluids. At 10 AM, the resident was offered a snack, which s/he ate, but no fluids were offered. b. Review of the fluid intake report for the month of November 2011 showed on 21 of 29 days during the month, the resident was not offered or provided any fluids between meals. Continued review of this document showed, while the resident sometimes refused fluids at meals, there was no evidence s/he refused fluids between meals. Review of this document also showed the resident had less than 1000 cc fluid intake on all but 2 of 29 days in November 2011. Interview with CNA #3 on 11/29/11 at 10:26 AM revealed the resident was often combative and difficult to work with. Interview with RN #1 on 11/30/11 at 3:10 PM revealed staff was to offer the resident fluids every time they passed him/her or had some interaction with the resident.	F 327	C) All staff will be educated regarding the importance of offering and providing adequate fluids to residents with appropriate documentation. D) Monitoring of compliance of staff will be done by weekly random rounds of the nurse supervisor and documented on the weekly in round sheet. until ~~the next state survey~~ substantial compliance has been met. LC E) Results will be reported quarterly as ~~part of the facility Quality Assurance~~ Program.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		

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F 425	Continued From page 16 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for use in 1 of 2 medication rooms. The findings were: 1. Observation on 11/30/11 at 2:15 PM of a bottle of Novalog insulin showed it was opened on 10/11/11 and was still available for administration on 11/30/11 which was twenty days after the 30 day expiration date. Interview with LPN #1 at the time verified the insulin was expired and should not be available for administration. 2. Observation on 11/30/11 at 2:15 PM showed there were three Phenergan 25 mg suppositories available for PRN (as needed) use for resident #44. Observation showed the expiration date was	F 425	The facility will ensure pharmaceutical services that assure the accurate acquiring, receiving, dispensing, and administering drugs are provided to meet the needs of each resident. The facility will ensure that A) All drugs that are expired are removed and stored in a locked area to be destroyed by DON and pharmacist. B) Charge nurses will perform weekly checks of all drugs to monitor for and remove expired medications ~~until the next state survey~~. Nurses on shift during presence of expired medication will receive immediate in-servicing and corrective actions will be taken. and document on the weekly/quarterly sheet substantial compliance has been met. KR D Ø) Results will be reported quarterly as part of the facility Quality Assurance Program. C. Education of staff (licensed nursing) will include checking for expired medication and how to dispose of those medications KR	12/30/11

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F 425	Continued From page 17 3/20/11 (eight months earlier). Interview with LPN #1 at the time verified the suppositories were expired and should be discarded.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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.	F 431	The facility will ensure drugs and biologicals used are labeled in accordance with currently accepted professional practices, and include the expiration date.	12/30/11

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F 431	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on random observations, staff interview and pharmacist interview, the facility failed to ensure all medications provided by the pharmacy were labeled with the expiration date in 2 of 4 medication carts. The findings were: 1. Random observation on 11/30/11 at 11:40 AM with RN #2 showed non-sample resident #57 had two cassettes each with the medication Hydrocodone/ acetaminophen 5/325 milligrams (mg) filled by a local pharmacy. It was ordered to be given 1-2 tablets every four hours as needed for pain. The RN verified the expiration date was not on the label. Interview with the pharmacist (#1) at the local pharmacy via phone on 11/30/11 at 1:25 PM stated the computer did not print the expiration dates on the labels of medications dispensed. Further, he was unaware medication labels required an expiration date. 2. Observation on 11/30/11 at 2:15 PM showed there was one 10 cc (cubic centimeter) syringe filled with Promethazine 25 mg for resident #67 that had no expiration date. Interview with LPN #1 at the time verified there was no expiration date but that based on the issue date it was more than one year old and should be discarded.	F 431	A) Medications for residents #57 and #67 will have expiration dates on them. B) Medications for all residents will have expiration dates on them and will be discarded by the expiration date. C) Charge nurses will perform weekly checks for expired medications and remove outdates as needed and signoff completed. E. D) Monitoring of compliance will be done by weekly random checks of medications by supervisors until ~~the next state survey~~ and documented on the weekly QA record sheet substantial compliance has been met. KR Nurses on shift with medications with no expiration dates or expired medications will receive immediate in-servicing and corrective actions will be taken. F. E) Results will be reported quarterly as part of the facility Quality Assurance Program. D All licensed nursing staff will be educated on checking medication to ensure all medications dispensed have an expiration date included. KR	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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F 441	Continued From page 19 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professionally accepted standards, the facility failed to disinfect	F 441	The facility will establish and maintain an Infection Control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.	12/30/11

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F 441	Continued From page 20 resident care equipment during two random observations, which affected 4 non-sample residents (#31, #42, #65, #69). In addition, the facility failed to follow acceptable infection control practices for 1 of 3 sample residents (#62) who had a urinary catheter. The findings were: Concerning glucometers: 1. According to the facility policy and procedure titled, "Blood Sugar Testing", revised 10/11, the meter and any other equipment coming in contact with the patient must be cleaned after use, prior to use on another patient. However, the "APIC position paper: Safe injection, infusion, and medication vial practices in health care" American Journal of Infection Control, Association for Professionals in Infection Control and Epidemiology (APIC), April 2010, provides the following information related to blood glucose monitoring devices: "Assign a glucometer to each individual patient if possible. Clean and disinfect glucometers if they must be shared between multiple patients. 2. During an observation on 11/29/11 from 11 AM through 11:30 AM, RN #3 performed glucose monitoring on three non-sample residents (#31, #42, #69) using a single LifeScan glucometer. The RN did not clean the glucometer at any time. During an interview immediately after the observation, the RN stated that the glucometers were cleaned by staff each night using SaniWipes (ammonia based), and there was one glucometer for each medicine cart that was utilized for multiple residents.	F 441	A) Glucometer equipment used on all residents including residents #31, #42, #65, #69, will be cleaned after use and prior to use on another resident when performing glucose monitoring. B) All staff will be educated regarding cleaning glucose monitoring equipment after each use. C) Monitoring of staff compliance will be done by weekly random rounds by supervisors until ~~the next state survey~~ and documented on the weekly Focus Sheet substantial compliance has been met. LLL Staff observed not cleaning glucometer equipment after each use will be give immediate in-servicing and corrective actions will be taken. D) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 441	Continued From page 21 3. Observation on 11/30/11 at 10:55 AM showed CNA #6 took the glucometer into non-sample resident #65's room and placed it on his/her side table. She then obtained the blood and tested the sample. The CNA carried the glucometer back to the nurses' station and placed it back into the case without first cleaning the meter. Interview with the CNA at that time stated she was not aware the glucometers were to be cleaned between residents. 4. During an interview on 11/30/11 at 2:30 PM, the infection control nurse stated the glucometers were to be cleaned after each resident use. Concerning urinary catheters: 1. Observation on 11/29/11 at 9:45 AM showed CNA #1 assisted resident #62 to the bathroom. After the resident was seated on the toilet, the CNA placed his/her foley catheter bag on the floor and left the bathroom. Interview with the CNA at that time acknowledged the foley bag was not to be placed directly on the floor, and returned to the resident to hang the foley bag on the walker. 2. Review of the policies and procedures for urinary catheter care, last reviewed 11/11/11, showed the catheter tubing and drainage bag were to be kept off the floor. 3. Interview with the infection control nurse on 11/30/11 at 2:30 PM revealed foley catheter bags were not to be placed directly on the floor.	F 441	A) The foley catheter bags for all residents including resident #62 will be placed in the correct and appropriate position. B) Education will be provided to all staff regarding correct placement of foley catheter bags. C) Compliance of staff will be monitored by weekly random rounds observing foley catheter bag placement until ~~the next staff survey~~. Staff observed not placing foley bags correctly will be given immediate in-servicing and corrective actions will be taken. D) Results will be reported quarterly as part of the facility Quality Assurance program.	and documented on the weekly CQI round sheet KL by the charge nurse KL substantial compliance has been met. KL
F 502 SS=D	483.75(j)(1) ADMINISTRATION	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

(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 502	Continued From page 22 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of manufacturer recommendations, the facility failed to ensure the test strips for resident blood glucose testing were not expired for 3 of 4 glucometers. Further, the controls used to test the accuracy of the glucometers were not labeled or were illegible with the date they were opened for 2 of 4 glucometers. The findings were: 1. Observation on 11/30/11 at 11:15 AM showed the glucose test strips located with two of two glucometers located on the first floor were not labeled with the date they were opened. In addition, the test strips with one of two glucometers on the second floor were not labeled with the date opened. The bottles were approximately three quarters full and available for use. The manufacturer instructions, displayed directly on the label, showed the test strips expired four months after they were opened. 2. Observation on 11/30/11 at 11:15 AM showed controls used to test the glucometers were not labeled with the date opened or the date it was opened was illegible for 2 of 4 glucometers. The manufacturers label showed the controls expired 90 days after they were opened. 3. Interview with RN #2 at the time of the observation verified the test strips and controls	F 502	The facility will provide or obtain laboratory service to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. A) All test strips and controls will be dated, legible when opened and discarded when expired. B) Education on dating and expiration date of strips and controls will be completed by all Certified Nursing Assistants and nurses. C) Compliance will be monitored by weekly rounds by nurse supervisor until ~~the next state survey.~~ Staff on shift with expired strips and controls or no dates on strips and controls will be given immediate in-servicing and corrective actions will be taken. D) Results will be reported quarterly as part of the facility Quality Assurance program.	12/30/11

and documented on the weekly QI round sheet.
→ substantial compliance has been met

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

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F 502	Continued From page 23 were not labeled and acknowledged they were to be marked with the open dates to determine expiration.	F 502		