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FORM APPROVED
OMB NO. 0938-0391

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

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 _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1116 LANE 12 LOVELL, WY 82431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of facility policies and procedures, the facility failed to ensure restraints were appropriate for two (#21, #65) of two sample residents with physical restraints. The findings were: 1. Observation on 3/6/06 at 6:30 PM revealed resident #21 utilized a wheelchair with a lap buddy (soft foam pad which hooks around the armrest bars) to prevent from rising. Observations on 3/7/06 at 7:45 AM and again at 12:30 PM revealed the lap buddy was left on the resident's wheelchair during dining. Interview with registered nurse #15 confirmed the device was for safety in preventing the resident from standing while in the wheelchair. She further confirmed the resident could not remove the lap buddy without assistance. Medical record review revealed an assessment for the physical restraint was lacking. Interview on 3/9/06 at 8:30 AM with the director of nursing (DON) confirmed there was not a restraint assessment completed for resident #21, and she stated one should have been done. 2. Observation in the pod 7 dining room on 3/7/06 at 8:20 AM revealed resident #65 was being assisted with his/her morning meal, and a lap restraint was on his/her wheelchair to prevent rising. Review of the resident record revealed an	F 221	The facility will ensure that residents will be free from restraints unless required to treat residents medical symptoms A) Resident #21 has been discharged to home. Resident #65 will have the lap buddy removed at intervals per facility policy. B) All residents with lap buddies will be reviewed for restraints. The lap buddies will not be available for general staff to apply. C) The physical and chemical restraint list will be reviewed monthly with the Medical Director. Restraints have been reviewed at the mandatory March staff meeting. D) Compliance will be monitored and reported monthly by the Nurse Supervisor as part of the facility Quality Assurance program. The restraint policy will be reviewed by nursing staff. All of the above will be completed by nursing staff to be monitored by D.O.N., A.D.O.N.	04/15/06

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

Pete Buttars | C.E.O. | 4-4-06

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.

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HEALTH FACILITIES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	Continued From page 1 assessment for the physical restraint and a signed consent; however, the care plan dated 11/23/05 revealed the restraint should be removed every two hours for 15 minutes. 3. According to the facility's policy and procedure for restraints dated 6/6/03, "Restraints will be used only with a written order from the physician...all residents with a written order for restraints will be evaluated by a committee...all restraints may be released while residents are under supervision of nursing staff, as long as the safety of the resident is not compromised..." Interview on 3/9/06 at 8:30 AM with the DON confirmed it was her expectation that lap buddies would be removed during dining for all residents and any time the residents were supervised by staff	F 221		
F 241 S3=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assure 1 (#38) of 13 sample residents was treated in a manner which maintained his/her dignity. The findings were: While standing in the common area between pods 7 and 6 on 3/8/06 at 2:55 PM, a resident was heard calling, "Help me. Please help me. I'm	F 241	The facility will promote care for residents in a manner and environment that maintains resident dignity. A) Resident #38 will receive care to maintain dignity and respect. B) Staff will respond appropriately and timely for all residents request for assistance. C) Resident dignity issues were reviewed at the Mandatory March Nursing Staff Meeting. Notices will be posted to remind staff to respond to residents in a timely and appropriate manner.	04/15/06 04/06/06

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F 241	Continued From page 2 In pain." Investigation revealed resident #38 lying in bed with the door wide open. The bed cover was pushed to the resident's feet, the resident was nude from the waist down, and his/her buttocks and lower legs were exposed to view of anyone walking down the hall. According to the 2/2/06 Quarterly Minimum Data Set assessment, the resident required extensive to total assistance from staff for activities of daily living. At 2:57 PM certified nurse aides (CNA) #36, #56, #75 walked past the room and did not cover or respond to the resident, who continued to call out for help. Again at 3:01 PM CNA #75 walked by the resident's room without responding to the resident's call for help. Interview with the director of nursing on 3/9/06 at 10:55 AM revealed it was her expectation that the aides should have assured the resident's dignity and responded to his/her needs.	F 241	b) The charge nurse will monitor performance including but not limited to random rounds as assigned by the Nurse Supervisor. Compliance will be reported monthly as part of the facility Quality Assurance Program. To be completed by Nursing staff.	04/06/06
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on random observation, a strong, pervasive foul odor, and staff interview, the facility failed to maintain adequate housekeeping of one resident room. The findings were: On 3/7/06 at 8:15 AM a strong, pervasive foul odor was detected in the east hallway of pod B. Further investigation revealed it was coming from room #943 where resident #7 resided. Resident	F 253	A) The mattress cover for resident #7 has been cleaned. B) All mattress covers will be checked for cleanliness and odor - daily C) Nursing staff will be instructed to report soiled mattress covers to housekeeping. Housekeeping will in-service nursing staff on proper cleaning techniques when they are unavailable. → every 6 months	04/18/06

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F 253	Continued From page 3 #7 was non interviewable. Observation on 3/7/06 at 8 AM with RN #15 revealed there was only a mattress cover on the bed, and a large stain was noticeable on the cover. RN #15 confirmed the foul smell was coming from this mattress cover, and stated it needed to be cleaned or replaced. Additional observation on 3/7/06 at 9:20 AM revealed the bed was made; however, the smell was still present. Interview with housekeeper #1 at this time revealed she made the bed, but had not reported any smell or the condition of the mattress to her supervisor or nursing staff. She further confirmed she had smelled the odor. Interview with the lead housekeeper on 3/8/06 at 12:10 PM confirmed she would expect to be notified of the poor condition of the mattress cover so it could be cleaned properly before the bed was made.	F 253	D) The Housekeeping Supervisor will monitor performance and report monthly as part of the facility Quality Assurance Program. To be completed by Nursing and Housekeeping staff.	
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272	The facility will conduct initial and periodic comprehensive, accurate assessments of residents functional capacity. A) Residents #3, #9, #18, #19, #29, #38, #40, #50, #65, #66, #69 and #17 will have a comprehensive assessment. Resident #21 has been discharged. Section AD for residents #40, #73, #69 and #18 will be completed. #70, and 65 The Section R2a for resident #38 will be completed. B) All residents will have accurately completed assessments including but not limited to	04/21/06

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F 272	Continued From page 4 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to complete comprehensive assessments in various areas for 13 (#3, #9, #16, #19, #21, #29, #38, #40, #60, #65, #68, #69, #70) of 13 sample residents. In addition, section AD for six (#21, #40, #73, #89, #68, #16) of six new admission Minimum Data Set (MDS) assessments done within the past year were not completed. Furthermore, Section R2a on the 10/16/05 annual MDS assessment was not completed for resident #38. The findings were: 1. Review of the 11/25/04 admission assessment revealed resident #3 triggered for further assessment of bowel and bladder incontinence. However, the medical record contained no evidence the facility performed comprehensive assessments of these areas. 2. Review of the 2/2/06 Resident Assessment Protocol (RAP) summary for resident #9 revealed he/she required comprehensive assessments	F 272	b) continued RAP summary report. All resident's assessments will be completed in a timely manner, and updated as needed. Using the RAI approved by the state c) The MDS Coordinator and ward clerk will review the MDS for completeness prior to filing the MDS in the resident's medical record. The MDS Coordinator will implement a new RAP summary process to include more information and comprehensive assessments.	

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F 272	Continued From page 6 including activities of daily living, urinary incontinence, falls, dental care, pressure ulcers, and psychotropic drug use. Further review of the RAP summary revealed the assessments for these areas were located in the 2/7/06 RAP note. However, review of this 2/7/06 RAP note revealed there was not a comprehensive assessment completed for any of these areas. 3. Review of the 10/07/05 RAP Summary Report for resident #19 revealed s/he triggered for assessments in cognitive loss/ dementia, communications, activities of daily living, psychosocial well-being, mood state, behavioral symptoms, falls and dehydration/ fluid maintenance. Further review of the RAP summary revealed the assessments for these areas were located in the 5/10/05, the 5/12/05, and the 5/13/05 RAP notes. However, review of these RAP notes revealed comprehensive assessments were incomplete for these areas 4. According to the 10/15/05 annual MDS assessment, resident #19 required further assessment in the areas of urinary incontinence, pain, falls, pressure sores, psychoactive medications, and oral status. Review of Section V (indicates location of assessment information and care plan decision) of that MDS showed the location of the assessment information, for all areas except pain, as "rap [Resident Assessment Protocol] note 10/18/05." However, review of that information revealed comprehensive assessments were not completed. Medical record review showed the last pain assessment was completed on 4/21/05. The resident sustained a hip fracture on 9/26/05, and the 10/15/05 annual and 12/26/05 quarterly MDS assessments documented the resident as having	F 272	D) The MDS Coordinator will monitor performance by random review of four charts per month including but not limited to RAPS and assessments and report monthly as part of the facility Quality Assurance program. All of the above; to be completed by MDS Coordinator, Ward Clerk and Nursing Staff. monthly To be monitored by MDS Coordinator and D.O.N. and A.D.O.N.	

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F 272	Continued From page 6 increased pain since 4/21/05. Interview with the resident on 3/6/06 at 6:17 PM and on 3/9/06 at 7:35 AM revealed the s/he still complained of pain. However, further review of the medical record showed a current pain assessment was lacking. In addition, the registered nurse assessment coordinator failed to sign Section R2a for the 10/13/05 annual assessment. According to the December 2002, Centers for Medicare & Medicaid Services (CMS) Revised Long-Term Care Resident Assessment Instrument (RAI) User's Manual, Version 2.0, Section R2a must be signed to certify the assessment is complete. 5. Review of the 12/12/06 RAP summary for resident #21 revealed s/he required comprehensive assessments for areas including delirium, cognitive loss, mood, visual function, communication, psychosocial well-being, urinary incontinence, falls, and activities. Further review of the RAP summary revealed the assessments for these areas were located in the 12/13/05 RAP note. However, review of this 12/13/05 RAP note revealed the assessments for these areas were incomplete. In addition, the resident had utilized a lap buddy on his/her wheelchair since 1/4/05, and there was no evidence a comprehensive assessment was completed. Interview with the director of nursing (DON) on 3/9/06 at 8:35 AM confirmed an assessment for the physical restraint was lacking. 6. Review of the 7/7/05 annual MDS assessment showed resident #29 required further assessments in the areas of pressure sores, activities of daily living, hydration, psychoactive medications, mood, and cognitive loss. According to Section V of that MDS, comprehensive	F 272		

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F 272	Continued From page 7	F 272		

assessment information was located in the 7/7/05 RAPs. However, review of the entire medical record failed to reveal any RAPs. Interview with the DON on 3/9/06 at 10:35 AM revealed the facility was unable to find any RAPs for the resident.

7. Review of the 5/5/05 RAP summary for resident #38 revealed he/she required comprehensive assessments for communication, visual function, and falls. Further review of the RAP summary revealed the assessments for these areas were located in the 5/5/05 RAP note. However, review of this 5/5/05 RAP note revealed the assessments for these areas were incomplete.

8. Review of the 6/2/05 RAP summary for resident #40 revealed s/he required comprehensive assessments for communication, urinary incontinence and indwelling catheter, falls, pressure ulcers, and dental care. Further review of the RAP summary revealed the assessments for these areas were located in the 5/31/05 and 6/1/05 RAP notes. However, review of these RAP notes revealed the assessments for these areas were incomplete.

9. According to the 11/23/05 annual MDS assessment, resident #50 was incontinent of bowel and bladder, and required further assessments in these areas. However, review of the entire medical record failed to reveal comprehensive assessments for incontinence.

10. Review of the 6/25/05 RAP summary for resident #45 revealed s/he required comprehensive assessments for urinary incontinence, falls, physical restraints, and

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F 272	Continued From page 8 psychotropic drug use. Further review of the RAP summary revealed the assessments for these areas were located in the 8/30/05 RAP note. However, review of this 8/30/05 RAP note revealed the assessments for these areas were incomplete. 11. Review of the 5/10/05 RAP Summary for resident #65 revealed s/he triggered for assessments in delirium, cognitive loss/dementia, visual function, communications, activities of daily living, urinary incontinence, mood state, falls, dehydration/fluid maintenance, dental care, pressure ulcers and psychotropic drug use. Further review of the RAP summary revealed the assessments for these areas were located in the 10/11/05 RAP note. However, review of this RAP note revealed comprehensive assessments were lacking. 12. According to the 08/19/05 admission MDS assessment, resident #69 required assessments in the areas of mood, behavior, and psychosocial adjustment. Review of the resident's medical record failed to uncover comprehensive assessments in these areas. 13. Review of the 7/31/05 RAP Summary for resident #70 revealed s/he triggered for assessments in delirium, cognitive loss/dementia, communications, activities of daily living, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, activities, falls, dehydration/fluid maintenance and psychotropic drug use. Further review of the RAP summary revealed the assessments for these areas were located in the 8/3/05 and the 8/4/05 RAP notes. However, review of these RAP notes revealed comprehensive assessments were incomplete for	F 272		

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F 272	Continued From page 9 these areas. 14. Interview with the DON and assistant DON on 3/8/06 at 11:30 AM confirmed there was no additional assessment information to review. 18. Review of the following admission Minimum Data Set (MDS) assessments revealed section AD (face sheet signatures) were incomplete. a. resident #40 admission MDS assessment dated 9/2/05 b. resident #21 admission MDS assessment dated 5/6/05 c. resident #16 admission MDS assessment dated 12/12/05 d. resident #82 admission MDS assessment dated 10/3/05 e. resident #69 admission MDS assessment dated 8/19/05 f. resident #73 admission MDS assessment dated 11/16/05 Interview with the DON on 3/9/06 at 10:55 AM confirmed section AD of the admission MDS assessments should be completed with a signature and date. According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Section AD, "All staff responsible for completing any part of the background (face sheet) information at admission must enter their signatures, titles, sections they completed, and the date they completed those sections."	F 272		
F 274 D&D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive	F 274		

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F 274	Continued From page 10 assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to complete a significant change assessment for two (#18, #19) of six sample residents who experienced significant changes in their condition. The findings were: 1. Observation on 3/7/06 at 7 AM showed resident #19 had a long scar on the left hip, which certified nurse aide (CNA) #33 stated was from a fracture. Review of 10/15/05 Minimum Data Set (MDS) assessment showed the resident was hospitalized for repair of a fractured hip on 9/26/05 and returned to the facility on 9/30/05. During an interview on 3/7/06 at 10:20 AM, the resident stated s/he walked and used the toilet independently before the fracture, but was now unable to walk alone. Comparison of the 7/21/05 MDS assessment with the one done on 10/15/05 showed the resident went from requiring limited assistance to needing total assistance with bed mobility,	F 274	The facility will ensure that a comprehensive assessment of a resident will be completed within 14 days after there has been a significant change in the residents' physical or mental condition. A) Residents #18 and #19 will have a comprehensive assessment completed. B) All residents will have a comprehensive assessment completed within 14 days after there has been a significant change in their physical or mental condition. C) Temporary problems and resident changes in condition will be reviewed weekly in the interdisciplinary team meeting. The MDS Coordinator will be responsible to notify members of the IDT when a significant change assessment is required.	04/21/06

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NEW HORIZONS CARE CENTER	1115 LANE 13 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 274	Continued From page 11 hygiene, ability to transfer, and ability to use the toilet, and range of motion went from no limitations to limited movement on one side of the leg and foot. Despite these changes, the facility failed to complete a significant change assessment by 10/13/05. Interview with the assistant director of nursing (ADON) on 3/8/06 at 6:10 PM confirmed lack of a significant change assessment. The ADON stated the MDS coordinator failed to dually code the completed assessment as a significant change and Medicare assessment. 2. Review of the medical record for resident #18 revealed a quarterly MDS assessment was completed on 8/11/05. The resident fell, fractured his/her hip and was hospitalized on 11/2/05, and then returned to the facility on 11/7/06. The facility did not complete a significant change MDS assessment upon the resident's return to the facility. However, they did complete several Medicare MDS assessments which showed a significant decline in the resident's abilities. Interview with the DON and ADON on 3/9/06 at 9:05 AM revealed a fractured hip would normally constitute the need to do a significant change assessment by the facility upon the resident's return to the facility. The DON and ADON stated the facility was unsure of the requirements for doing a quarterly, a significant change, and Medicare MDS assessments after a resident was released and then returned to the facility.	F 274	Nursing staff will be instructed in the April Mandatory Nursing Staff Meeting the procedure for reporting temporary problems and changes in condition. D) Performance will be monitored by the MDS Coordinator and reported monthly as part of the Facility Quality Assessment program. All of the above to be completed by MDS Coordinator and Nursing Staff. monthly To be monitored by MDS Coordinator, D.O.N. and A.D.O.N.	
F 275 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.	F 275		

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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 _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1116 LANE 13 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 276	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and review of the computer generated assessments record, the facility failed to complete an annual Minimum Data Set (MDS) assessment for one (#3) of eight sample residents who required that assessment. The findings were: Review of the admission MDS showed a completion date of 11/25/04. Review of the remaining assessments revealed they were either quarterly MDS or Medicare required assessments. Review of the computer generated assessment record with the assistant director of nursing (ADON) on 3/8/06 at 6:12 PM confirmed lack of an annual or significant change MDS assessment. The ADON stated it was "just missed."	F 275	F275 The facility will ensure that a comprehensive assessment of a resident's [illegible] every 12 month. a. Resident No. 3 will have a comprehensive assessment. b. All residents will have a comprehensive assessment ~~within the required time~~ Not less than once every 12 months c. The MDS Coordinator will implement a monitoring tool to check assessment due dates and notify IDT members of assessments due. d. The MDS Coordinator will monitor performance and report monthly as part of the facility QA program. To be completed by MDS Coordinator. To be monitored by MDS Coordinator, D.O.N. and A.D.O.N.	04/18/06
F 276 SS=D	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete a quarterly assessment for one (#18) of 14 residents. The findings were: Review of the medical record for resident #18	F 276	F276 The facility will ensure that resident quarterly assessments will be completed not less than once every three months. a. Resident No. 18 will have quarterly assessments completed. b. All residents will have quarterly assessments completed not less than once every three months. c. The MDS Coordinator will implement a monitoring tool to check assessment due dates and notify IDT members of assessments due.	04/18/06

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NEW HORIZONS CARE CENTER	1115 LANE 13 LOVELL, WY. 82431

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F 276	Continued From page 13 revealed a quarterly Minimum Data Set (MDS) assessment was completed on 8/11/05. Additional review revealed the next quarterly MDS assessment was completed on 12/10/05. Interview with the director of nursing (DON) and assistant DON (ADON) on 3/9/06 at 9:06 AM revealed the facility should have completed a quarterly assessment by 11/11/05. The DON and ADON stated the facility was unsure of the requirements for doing a quarterly, a significant change and Medicare MDS assessments after a resident was released and then returned to the facility.	F 276	F276 d. The MDS Coordinator will monitor performance and report monthly as part of the facility QA program All of the above will be completed by MDS Coordinator. To be monitored by D.O.N. and A.D.O.N.	
F 276 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $6,000 for each	F 278	F278 The facility will ensure that resident assessments accurately reflect the resident's status. a. Resident No. 19, 29, 38 and 69 will have MDS assessements that accurately reflect their status. b. All residents will be reviewed on their scheduled dates for accuracy. c. The IDT members will review their sections of the printed MDS for accuracy during the weekly IDT meeting. d. The MDS Coordinator will monitor accuracy of assessments including but not limited to reviewing two MDS's every month and report monthly as part of the facility QA program. All of the above to be completed by MDS Coord.	04/18/06

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	538030	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1216 LANE 12 LOVELL, WY 82431

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F 275	Continued From page 14 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, medical record review, and review of documented statements, the facility failed to assure Minimum Data Set (MDS) assessments accurately reflected the status of 4 (#19, #29, #38, #59) of 15 sample residents. The findings were: 1. Observation on 3/7/06 at 7 AM showed resident #19 had a long scar on the left hip, which certified nurse aide (CNA) #33 stated was from a fracture. Review of 10/18/05 MDS assessment showed the resident was hospitalized for repair of a fractured hip on 9/26/05 and returned to the facility on 9/30/05. During an interview on 3/7/06 at 10:20 AM, the resident stated s/he ambulated independently before the fracture, but was unable to walk alone now. Review of the 10/18/05 MDS assessment showed the resident had significant changes in multiple areas (refer to F274 for information related to the changes). Despite the changes, the facility coded Section Q2 (overall change in condition) as "No change." Interview with the director of nursing (DON) and assistant director of nursing (ADON) on 3/8/06 at 5:20 PM revealed they had no idea why the section was coded "No change." According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Section Q2	F 275	To be monitored by MDS Coordinator, D.O.N. and A.D.O.N.	

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	536036	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1116 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 278	Continued From page 15 should "monitor the resident's overall progress at the facility over time." 2. According to the 1/5/06 quarterly MDS assessment, resident #29 declined in the following areas: behaviors, hygiene, range of motion, and toilet use. Despite these documented changes, Section Q2 was coded "No change." Interview with the DON on 3/9/06 at 7:55 AM revealed the facility changed who did the assessments and she felt this might cause the discrepancy. Upon request, the DON and ADON re-evaluated the resident and determined there was no change in the resident's abilities. The documented statement read: "This RN feels any changes or MDS are inaccurate as there is no notable change in function." According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Section Q2 should "Monitor the resident's overall progress at the facility over time." 3. Review of the medical record revealed resident #38 had a diagnosis of bladder spasms and a physician's order dated 3/13/06 for an indwelling urinary catheter. Observation on 3/6/06 at 6:10 PM confirmed the resident used a urinary catheter. Review of the 5/5/05 annual MDS assessment showed the resident had an indwelling catheter at that time. However, review of the 2/2/06 quarterly MDS assessment did not show the resident utilized any type of catheter. Interview with the DON on 3/9/06 at 10:25 AM confirmed the resident utilized a catheter during the 2/2/06 assessment period, and the coding was inaccurate.	F 278		

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	535030	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1418 LANE 12 LOVELL, WY 82431

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F 278	Continued From page 16 4. According to the 08/19/05 admission MDS assessment, resident #69 was documented in Section O4 to have received antianxiety medication (buspirone hydrochloride: BuSpar) for each of 7 days prior to the assessment. This annotation was consistent with the resident's medication administration records (MARs). However, the 11/16/05 quarterly MDS assessment failed to document this resident's continued use of antianxiety medications. Review of the MARs revealed resident #69 continued to receive BuSpar 3 times a day during the assessment interval. Observation on 03/8/06 at 4:15 PM revealed the resident received a 10 milligram tablet of BuSpar, a fact confirmed by interview on the same date and time with the nurse who administered it. According to the Centers for Medicare & Medicaid Services Revised Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002 (Revised August 2005), Section O should include "All medications used by the resident in the 7-day assessment period "...with specific instructions for Section O4 to record " ...the number of days that the resident receives each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days."	F 278		
F 282 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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NEW HORIZONS CARE CENTER	1113 LANE 12 LOVELL, WY 82431

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F 282	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and review of restorative care plans, the facility failed to follow the plans of care developed for four (#19, #21, #30, #65) of 6 sample residents who required restorative services. The findings were: 1. Observation on 3/7/06 at 7 AM showed resident #19 was transferred from the bed to a recliner with a mechanical lift. During the observation, certified nurse aide (CNA) #33 stated the resident could not walk due to the fractured hip. The CNA further stated the resident used to receive therapy but was now on restorative exercises; however, the restorative exercises had not been done for a "long time" as they took three staff members to complete. During an interview on 3/7/06 at 10:20 AM, the resident stated s/he had not received restorative exercises for some time. Review of the restorative care plan developed by physical therapy (PT) showed resident #19 was to receive restorative services five times a week to improve bed mobility, balance, posture, weight bearing, transfer, and ambulation. Exercises developed on 12/13/05 by the occupational therapy (OT) department included upper extremity exercises with a red theraband, biceps curls, triceps extension, and shoulder abduction; all OT exercises were three times a week as tolerated. Review of the documentation for the program showed the resident did not receive upper extremity exercises at all. The program developed by PT was not performed at all in March 2006, was done three times in February 2006, 7 times (with two refusals) in January 2006, and 5 times in	F 282	F282 The facility will ensure that residents will receive restorative therapy as ordered by their plans of care. a. The plan of care for residents, 19, 21, 30 and 65 will be reviewed and updated for their restorative programs. b. The plans for each resident receiving restorative therapy will be reviewed. c. The restorative staff will review their resident list and plans monthly for compliance. d. Compliance will be monitored and reported weekly to the Interdisciplinary Team by the Restorative Nurse. Inservice will be provided by O.T. and/or P.T. department to Restorative Staff. All of the above to be completed by O.T./P.T. dept., Restorative Staff. To be monitored by O.T./P.T. dept., Nursing Supervisor, D.O.N., A.D.O.N.	04/18/06

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	635030	A. BUILDING _____ B. WING _____	03/05/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1115 LANE 12 LOVELL, WY 83431

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F 282	Continued From page 18	F 282		

December 2005.

During an interview on 3/9/06 at 11:25 AM, restorative aide (RA) #52 stated that the program was not provided if it was not documented as done. The RA also stated they did not have time to do the program five times a week as ordered

2. Review of the 1/26/06 restorative care plan for resident #21 showed bilateral lower extremity stretching was to be done five times per week. However, review of the January and February 2006 restorative documentation revealed the stretching was only done three times per week with no refusals documented.

3. According to the restorative care plan developed by PT, resident #60 was to ambulate with assist of two staff. Staff were also to work on gradually opening the resident's left hand. The entire program was ordered for five times a week, and was continued on 9/12/05 and "as [resident] tolerates" on 1/18/06. Review of the restorative documentation showed that during March 2006 the program was completed three times by March 6th (3/3/06 documented as unable to complete), four times a week for the first two weeks and three times during the third week in January 2006, and only 13 out of 22 possible times in December 2006.

During an interview on 3/9/06 at 11:25 AM, restorative aide (RA) #52 stated that the program was not provided if it was not documented as having been done.

4. Review of the 1/19/06 restorative care plan for resident #65 showed restorative nursing was to get the resident involved in group exercises and discontinue the ambulation program. However, interview with the director of nursing, the

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NEW HORIZONS CARE CENTER	1115 LANE 12 LOVELL, WY 82431

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F 282	Continued From page 19 restorative RN, and three restorative CNAs on 3/9/06 at 11:25 AM revealed they were unaware of this change to the care plan and continued to provide the plan as written on 1/25/05 with a goal of ambulation five times per week. Review of the January and February 2006 restorative documentation revealed ambulation was provided five times per week only one of the four weeks in January, and only one of the four weeks in February 2006. During both January and February 2006 there were no documented refusals from the resident.	F 282		
F 311 96=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to provided restorative services as ordered to improve the physical capabilities of one (#19) of five sample residents. The findings were: Observation on 3/7/06 at 7 AM showed resident #19 was transferred from the bed to a recliner with a mechanical lift. The resident also had a long scar on the left hip, which certified nurses aide (CNA) #33 stated was from a fracture. The CNA stated the resident could not walk due to the fractured hip. The CNA further stated the resident used to receive therapy but was now on restorative exercises; however, the restorative exercises had not been done for a "long time" as	F 311	F311 The facility will ensure that residents will receive restorative therapy as ordered. a. Resident No. 19 will be re-evaluated by occupational and physical Therapy and an updated restorative program will be put into place. b. The program for each resident assigned to restorative will be reviewed monthly. c. The restorative staff will review their resident list monthly to ensure that each resident is meeting their plan. d. Compliance will be monitored and reported weekly to the Interdisciplinary Team by the restorative nurse. O.T. and/or P.T. department will inservice Restorative staff.	04/18/06

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1110 LANE 19 LOVELL, WY 82431

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F 311	Continued From page 20 they took three staff members to complete During an interview on 3/7/06 at 10:20 AM, the resident stated, that prior to the fracture, s/he ambulated independently and used the toilet as needed. The resident confirmed s/he had not received restorative exercises for some time and stated s/he was now incontinent and confined to a chair. Review of 10/15/05 Minimum Data Set (MDS) assessment confirmed the resident was hospitalized for repair of a fractured hip on 9/26/05 and returned to the facility on 9/30/05. Review of the occupational therapy (OT) evaluation and progress notes showed the resident was referred to the restorative program for upper extremity exercises on 12/13/05. Review of the medical record showed a physician's order, dated 11/17/05, for full weight bearing. According to notes from the restorative program, physical therapy referred the resident to that program on 12/7/05. The note documented the resident stood with assistance from two staff and a gait belt and took three steps; another restorative aide brought the resident's wheelchair right behind the resident. The notes further documented the resident took several steps inside the parallel bars. The following concerns with the restorative program were identified: a. The program remained unchanged after the resident's fractured hip. The plan was to improve the resident's mobility using minimal assistance, ambulate the resident with a front wheeled walker, and use the moving steps; all modalities were for five times a week. b. Upper extremity exercises were not done as ordered by OT c. The program was not provided five times per week as ordered. d. The restorative program as practiced did	F 311	All of the above will be completed by Restorative staff and O.T./P.T. To be monitored by O.T./P.T. dept., restorative, Nursing supervisor, D.O.N. and A.D.O.N.	

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F 311	Continued From page 21 not agree with the Restorative/Maintenance Exercise Program as developed on 3/15/06. Those instructions were "Bring to rest. [restorative] room for ex. [exercises] & amb [ambulation] 2 x / [two times per] week." On 9/12/06 and 1/16/06 [06] the physical therapist wrote, "Cont. [continue] program." e. Interview with the restorative director, restorative staff, director of nursing (DON), and assistant director of nursing (ADON) on 3/9/06 at 11:25 AM confirmed the resident had not received restorative services since 2/27/06. Prior to that date, the program was done on 2/7/06 and 2/14/06. The restorative staff stated they did not have time to complete the program five times a week as ambulating the resident took all three of them. The DON confirmed the program was set up by physical therapy but was not re-evaluated and revised after the resident's fracture. Restorative aide #59 stated there were "several times" when only one restorative aide was on duty.	F 311		
F 312	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, medical record review, and review of policies and procedures, the facility failed to assure staff provided appropriate personal care for dependent	F 312	F312 The facility will ensure that residents will receive good perennal and oral hygiene. a. Residents no. 3, 9, 4, 6 and 31 will receive appropriate personal care. Resident no. 31 will receive ~~appropriate~~ oral care. as per facility policy & procedure b. All residents will receive ~~appropriate~~ perineal care and oral care. c. Mandatory inservice regarding appropriate perineal care will be provided by the	04/18/06

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1118 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 312	Continued From page 22 residents. During seven observations of perineal (incontinence) care provided for incontinent residents, five (sample residents #3, #9 and non-sample residents #4, #6, #31) were completed incorrectly. In addition, staff failed to provide appropriate oral care for non-sample resident #31. The findings were: 1. Observation on 3/8/06 at 7:10 AM showed resident #6 was incontinent of urine. The resident was wet from groin to feet; the left sock was also wet. Two certified nurse aides (CNAs, #66 and #37) assisted the resident and changed his clothing. However, when the CNAs provided perineal care, they wiped around the penis, but failed to retract the foreskin and cleanse the glans. In addition, they failed to cleanse the scrotal and groin area, the anal area, and the resident's legs. At the end of the observation, CNA #66 confirmed the resident was uncircumcised and stated the resident's foreskin was only retracted and cleansed at night. According to the facility's January 2002 policy and procedure, "Perineal Care," incontinence care for men included "retract the foreskin of the uncircumcised male...wash the perineal area including the penis, scrotum, and inner thighs...wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks." The policy and procedure did not address cleansing other areas of skin in contact with urine. 2. Observation on 3/8/06 at 3:13 PM showed resident #9 was continent of urine when toileted. However, CNA #35 first cleansed the resident's buttocks, then cleansed the perineum with the same area of the wipe. With a second wipe, the CNA then cleansed the perineal area, wiping from	F 312	F312 staff development coordinator. The "Perineal Care" policy and procedure will be updated to include cleansing other areas of skin in contact with urine. Providing oral care to confused residents will be reviewed at the April mandatory nursing staff meeting. d. Performance will be monitored by the charge nurse including but not limited to random perineal and oral care observation as assigned by the nurse supervisor and reported monthly as part of the facility QA program. To be completed by Nursing Staff. To be monitored by Nursing Supervisor, D.O.N. and A.D.O.N.	04/16/06

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	525830	A. BUILDING _____ B. WING _____	03/09/2006

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F 312	Continued From page 23	F 312		

the back towards the front. Review of the facility's aforementioned policy and procedure for perineal care showed "Maintain clean technique...Wash perineal area, wiping from front to back...Do not use the same washcloth [or area of a wipe]."

3. Observation on 3/8/06 at 8:30 AM showed CNAs #85 and #87 assisted resident #31 to the bathroom. The CNAs stated the resident was incontinent of urine when toileted. However, they failed to cleanse the resident's anterior groin and perineum. According to the aforementioned policy and procedure, perineal care should include cleansing all the perineum and inner thighs, as well as the rectal area and buttocks.

After completion of perineal care, the CNAs washed the resident's face. The resident was confused and needed encouragement to allow this, but was not combative or abusive to the staff. When asked about oral care, the resident acted as if s/he did not understand the question. The CNA repeated the question , and the resident responded, "I'll cut them out!" The CNAs made no further attempt to explain what they wanted the resident to do, show him/her the toothbrush or toothpaste, or encourage the resident to complete oral care. They just smiled and assisted the resident to dress.

4. Observation showed resident #9 was continent when toileted on 3/8/06 at 4:25 PM. However, CNA #85 cleansed the resident's buttocks, and then the perineal area, with the same area of the second wipe. Review of the facility's aforementioned policy and procedure for perineal care showed "Maintain clean technique...Wash perineal area, wiping from front to back...Do not use the same washcloth [or area of a wipe]."

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F 312	Continued From page 24 5. Observation revealed resident #4 was continent of feces when toileted on 3/8/06 at 3:20 PM. However, CNA #35 first cleansed the residents upper buttocks, then used the same area of the wipe to cleanse the perineum. Review of the facility's aforementioned policy and procedure for perineal care showed "Maintain clean technique...Wash perineal area, wiping from front to back...Do not use the same washcloth (or area of a wipe)." 6. According to the November 2001 "Nurse Aide Written (or Oral) Examination and Skills Evaluation Candidate Handbook," a required critical element for passing skill 12, "Provides Perineal Care for Incontinent Client" was "Washes entire perineal area, moving from front to back, while using a clean area of the washcloth or clean washcloth for each stroke."	F 312		
F 315 DSHS	483.25(d) URINARY INCONTINENCE 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, resident and staff interviews, and medical record review, the facility	F 315	F315 The facility will ensure that the Bowel and Bladder (B&B) assessment and plan for each resident is current and includes appropriate nursing interventions. a. Resident No. 19 will have a current assessment and plan of care completed by the B&B nurse. b. The B&B nurse will ensure that each resident will have a B&B assessment plan of care done quarterly and as needed. c. B&B plans will be updated and included on the CNA sheets.	4-18-06 weekly

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F 315	Continued From page 25 failed to prevent avoidable urinary incontinence for one (#19) of one sample residents who was capable of remaining continent. In addition, staff completed catheter care incorrectly for one (#38) of one sample residents with an indwelling urinary catheter. The findings were: 1. Review of the 10/15/05 annual and 12/26/05 quarterly Minimum Data Set (MDS) assessments revealed resident #19 was cognitively intact and was continent of bowel and bladder with the use of an indwelling urinary catheter. Review of nursing notes showed the catheter was discontinued on 1/19/06, and the notes dated 2/17/06 documented the resident had a "urine burn shallowly in the sitz area (inner thighs, bilateral buttocks, and peri (perineal) area) Review of the last urinary incontinence assessment showed it was completed on 10/16/05; no assessment was completed after the catheter was discontinued. Review of the care plan for altered elimination showed it did not provide any instructions related to toileting the resident and preventing urinary incontinence. Observation on 3/7/06 at 7 AM showed perineal care was provided for the resident. During the observation, certified nurse aide (CNA, #33) stated the resident was incontinent of urine and had small open areas on the buttocks since the indwelling catheter was discontinued. The resident was then transferred per mechanical lift onto an incontinence pad which was placed in the recliner. Observation on 3/7/06 at 9:43 AM showed CNA #33 checked the resident's incontinence pad and provided perineal care. The CNA did not ask the resident if s/he needed to use the toilet or offer to take him/her to the bathroom. However, the CNA did state the resident was continent of bowel, was toileted for a	F 315	F315 d. The DSS nurses will make random compliance rounds with the staff to ensure resident plans are being followed. This will be reported as part of the facility CQI program. F315 The facility will also ensure that catheter care is done in a proper manner. a. Resident no 38 will have correct catheter care completed. b. Remediation will be done with the CNA that provides incorrect care. c. Staff training on proper peri and catheter care will be done by the Staff Development Coordinator. d. The catheter care policy will be updated and reviewed in the April mandatory nursing staff meeting. e. Performance will be monitored by the charge nurse by random observation rounds as assigned by the nurse supervisor and reported monthly as part of the facility QA program. Social Services will provide Nursing staff with inservice regarding patient dignity.	4-18-06 of a minimum weekly

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	535039	A. BUILDING _____ B. WING _____	03/09/2006

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F 316	Continued From page 26 bowel movement and, if requested, for urination; otherwise, the resident was just checked and changed when incontinent. Interview with the resident on 3/7/06 at 10:20 AM revealed s/he walked and toileted him/herself independently before sustaining a fractured hip. The resident stated, "I miss that." The resident also stated s/he was not toileted now as s/he "can't walk." In addition, the resident stated s/he was frequently left wet for half a day before being checked and changed. When asked how that made him/her feel, the resident replied, "Not too good...feels like a baby," and the resident indicated s/he did not like the feeling. Furthermore, the resident stated s/he did not like to ask for help as the staff "are busy." Finally, the resident stated, "There's nothing wrong with my mind." Interview with the director of nursing (DON) on 3/8/06 at 9:40 AM revealed her expectation was that staff would toilet the resident. The DON confirmed the resident was cognitively intact and could express his/her needs. 2. Observation at 9:08 AM on 3/7/06 revealed resident #38 had an indwelling urinary catheter but was toileted and was continent of bowel. The observation also showed the resident had fecal material on the urinary catheter. CNA #90 cleansed the catheter of feces, then used the contaminated area of the wipe to complete catheter care. Interview with the DON on 3/8/06 at 10:45 AM revealed she expected staff to use a clean area of a wipe to perform catheter care. On 3/8/06 at 2:40 PM the DON stated she was unable to find a policy and procedure for catheter care.	F 316	All of the above to be completed by Nursing staff and Social Services. To be monitored by Nursing Supervisor, D.O.N. and A.D.O.N.	
F 318	483.25(e)(2) RANGE OF MOTION	F 318		

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F 318 SS=E	Continued From page 27 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to assure restorative services were provided as ordered for four (19, #21, #50, #65) of six sample residents who were on a restorative program. The findings were: 1. During an observation on 3/7/06 at 7 AM, certified nurse aide (CNA) #33 stated resident #19 could not walk due to a fractured hip. The CNA further stated the resident was now on restorative exercises; however, the restorative exercises had not been done for a "long time" as they took three staff members to complete. During an interview on 3/7/06 at 10:20 AM, the resident stated s/he had not received restorative exercises for some time. Review of the restorative program developed by physical therapy (PT) showed the resident was to receive restorative services five times a week to improve bed mobility, balance, posture, weight bearing, transfer, and ambulation. Exercises developed on 12/13/05 by the occupational therapy (OT) department included upper extremity exercises with a red theraband, biceps curls, triceps extension, and shoulder abduction; all OT exercises were three times a week as	F 318	F318 The facility will ensure that residents will receive their restorative therapy exercises as ordered by their plans of care. a. The plan of care for residents 19, 21, 50 and 65 will be reviewed and updated for their restorative programs. b. The plans for each resident receiving restorative therapy will be reviewed. c. The restorative staff will monitor restorative resident plans for completeness and report any problems to the Restorative Nurse. — weekly d. Compliance will be monitored and reported weekly to the Inter-disciplinary Team by the Restorative Nurse. P.T. and/or O.T. dept. will inservice staff regarding the above. — monthly To be completed by P.T./O.T., Nursing. To be monitored by O.T./P.T., Nursing, D.O.N. and A.D.O.N.	4-18-06

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F 315	Continued From page 28 tolerated. Reviewed of the documentation for the program showed the resident did not receive upper extremity exercises at all. The program developed by PT was not performed in March 2006, was done three times in February 2006, 7 times (with two refusals) in January 2006, and 5 times in December 2005. 2. Review of the 1/25/06 restorative program for resident #21 showed bilateral lower extremity stretching was to be done five times per week. However, review of the January and February 2006 restorative calendar revealed the stretching was done three times per week, and there were no refusals documented. 3. According to the restorative program developed by PT, resident #60 was to ambulate with assistance of two staff. Staff were also to work on gradually opening the resident's left hand. The entire program was ordered for five times a week, and was continued on 8/12/05 and "as (resident) tolerates" on 1/16/06. Review of the restorative documentation showed that during March 2006 the program was completed three times by March 8th (3/3/06 documented as unable to complete), four times a week for the first two weeks and three times during the third week in January 2006, and only 13 out of 22 possible times in December 2005. 4. Review of the 1/16/06 restorative program for resident #65 showed restorative staff were to get this resident involved in group exercises and discontinue the ambulation program. However, interview with the director of nursing, the restorative RN, and three restorative CNAs on 3/9/06 at 11:25 AM revealed they were unaware of this change to the care plan and continued to	F 315		

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F 318	Continued From page 29 provide the plan as written on 1/25/05 with a goal of ambulation five times per week. Review of the January and February 2006 restorative documentation revealed ambulation was provided five times per week only one of the four weeks in January, and only one of the four weeks in February 2006. During both January and February 2006 there were no documented refusals from the resident. 5. During the interview on 3/9/06 at 11:25 AM described in #4 above, restorative aide (RA) #52 stated that the program was not provided if it was not documented as done. The RA also stated they did not have time to do many programs five times a week as ordered. Further interview revealed, that due to restorative staff absences or RAs being pulled to the floor, residents sometimes didn't get the services as ordered. Restorative aide #59 stated there were "several times" when only one restorative aide was on duty. The DON stated it was her expectation that residents be re-evaluated quarterly by therapy, but this had not been done. Further interview with the director of nursing, the restorative RN (#15), and three restorative CNAs (#52, #59, and #60) on 3/9/06 at 11:25 AM revealed due to restorative staff absences, or being pulled to the floor, sometimes residents didn't get the services as ordered.	F 318		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323	F323 The facility will ensure that the resident environment remains as free from hazards as possible a. The rooms on the SCU and TCU will be secure unless staff	4-18-06

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F 323	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hazard free environment in two of two restorative rooms. The findings were: Observation of the facility throughout the survey from 3/6/06 to 3/9/06 revealed the carpet in both the transitional care unit (TCU) and the secure care unit (SCU) restorative rooms was worn and starting to fold over itself in multiple places, thus creating a trip hazard. Interview on 3/8/06 at 2:10 PM with CNA #62 revealed the restorative room in the TCU was usually locked. However, on 3/8/06 it was unlocked because a restorative aide had forgotten her key. The CNA also confirmed the wrinkled carpet had previously been reported to administration as a hazard. Interview on 3/9/06 at 9:15 AM with CNA #64 revealed the door to the SCU restorative room was not closed. Observation throughout the survey revealed the restorative room in the SCU was never closed or locked.	F 323	F323 is available to monitor resident safety. b. The facility will replace the carpet in the TCU & SCU. c. Providing a hazard-free environment was reviewed in the mandatory March Nursing Staff meeting. d. Maintenance will monitor the facility carpet and report hazards to the facility Administrator. A time limited waiver is requested for the above in order to obtain plan approval from the Department.	7-6-06
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353	F353 The facility will ensure staff is available to provide care and services for residents in a timely manner. a. Residents No. 4 and 36 will receive services/care in a timely manner. b. All residents will receive care in a timely manner. c. Staff availability and responsibility to care for residents was discussed in	4-18-06

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F 353	Continued From page 31 care to all residents in accordance with resident care plans. Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interviews, and review of meeting minutes, the facility failed to assure staff were available to provide care and services for residents in a timely manner. The census at the time of the survey was 72. The findings were: 1. Observation on 3/8/06 at 2:35 PM revealed resident # 4 was seated in the TV area with two family members. One of the family members approached the surveyors to ask for assistance in taking the resident to the bathroom. Observation and a search of the area at that time revealed there were no staff available on pod 7 or 8 until registered nurse (RN) #15 came off of the elevator at 2:40 PM. As the RN turned towards pods 5 and 6, the surveyor got her attention. After checking the medication room and the back area (elapsed time of one minute), the RN then assisted the resident to the bathroom. 2. Observation at 2:52 PM revealed CNAs #35, #56, and #76 came into the TV area together. Interview with CNA #35 at 3:10 PM on 3/8/06	F 353	F353 the March mandatory nursing staff meeting. Notices will be placed in staff report/break rooms to remind staff to answer call bells in a timely manner and not to congregate. d. Performance will be monitored by the charge nurse, including but not limited to, random rounds as assigned by the nurse supervisor and reported monthly as part of the facility QA program. Staff who fail to perform their duties will be subject to disciplinary action. To be completed by Nursing. To be monitored by Nursing Supervisor, D.O.N. and A.D.O.N.	4-18-06

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F 353	Continued From page 32 revealed they were all in a room "getting report." 3. Observation on 3/8/06 at 2:55 PM revealed resident #36 was lying on his/her bed exposed from the waist down. The door to the resident's room was wide open, and the resident was calling out for help. Three CNAs walked by at 2:57 PM but did not stop and assist the resident. 4. Interviews with two family members, the first on 3/7/06 at 2:10 PM and the second on 3/8/06 at 11:35 AM, revealed staffing was an issue. Both family members stated they were frequently unable to find any staff to assist with residents. The first family member stated call lights were not usually answered as quickly as they were during the survey. During a confidential meeting on 3/8/06 at 1:15 PM, 13 residents agreed assistance was provided slower at night. 5. Observation on 03/08/06 at 2:15 PM revealed staff were absent from the nurses' station on the first floor. Upon searching, 3 staff members were found congregated in a back room used as a staff break area and resident food storage unit, an enclosed room lacking visual line-of-sight to resident or common areas. 6. Interview with the director of nursing (DON) on 3/9/06 at 10:55 revealed staff are not to all leave the floor at once. The DON stated this had been discussed at staff meetings. On 3/9/06 at 11:57 AM, the DON stated she has had a problem getting staff not to congregate together. Review of the minutes for the 1/17/06 nursing staff meeting also revealed "There have been some reports of staff sleeping on the night shift. If this is becoming a problem, call one of the supervisors..."	F 353		

DEPARTMENT OF HEALTH AND HUM[illegible]ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2006
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
	530030	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1114 LAKE ST 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 353	Continued From page 33 Restorative Services: 1. Review of the restorative program developed by physical therapy (PT) showed resident #19 was to receive restorative services five times a week to improve bed mobility, balance, posture, weight bearing, transfer, and ambulation. Exercises developed on 12/13/05 by the occupational therapy (OT) department included upper extremity exercises with a red theraband, biceps curls, triceps extension, and shoulder abduction; all OT exercises were three times a week as tolerated. Reviewed of the documentation for the program showed the resident did not receive upper extremity exercises at all. The program developed by PT had not been provided in March by 3/9/06, was provided three times in February 2006, 7 times (with two refusals) in January 2006, and 5 times in December 2005. 2. Review of the 1/25/06 restorative care plan for resident #21 showed bilateral lower extremity stretching was to be done five times per week. However, review of the January and February 2006 restorative calendar revealed the stretching was done three times per week, and there were no refusals documented. 3. According to the restorative program developed by PT, resident #50 was to ambulate with assistance of two staff. Staff were also to work on gradually opening the resident's left hand. The entire program was ordered for five times a week, and was continued on 5/12/05 and "as (resident) tolerates" on 1/16/06. Review of the restorative documentation showed that during March 2006 the program was completed three times by March 8th (3/3/06 documented as	F 353	F353 a. Resident No. 19, 50 and 65 will have restorative services as care planned. Resident No. 21 has been discharged. b. All residents on a restorative Plan will receive services as care planned. c. The Restorative Nurse and Restorative CNA's have implemented a time management tool. Restorative CNA's will be appropriately scheduled. d. Performance will be monitored by the Restorative Nurse and reported weekly as part of the facility QA program P.T. and/or O.T. will inservice Restorative Staff. To be completed by P.T./O.T., Nursing and Restorative. To be monitored by Nursing Supervisor, Restorative, D.O.N. and A.D.O.N.	4-18-06 every 6 months

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	336090	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1116 LANE 13 LOVELL, WY 82431

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F 353	Continued From page 34 unable to complete), four times a week for the first two weeks and three times during the third week in January 2006, and only 13 out of 22 possible times in December 2005. 4. Review of the 1/16/06 restorative care plan for resident #56 showed restorative nursing was to get the resident involved in group exercises and discontinue the ambulation program. However, interview with the director of nursing, the restorative RN, and three restorative CNAs on 3/9/06 at 11:25 AM revealed they were unaware of this change to the care plan and continued to provide the plan as written on 1/25/05 with a goal of ambulation five times per week. Review of the January and February 2006 restorative documentation revealed ambulation was provided five times per week only one of the four weeks in January, and only one of the four weeks in February 2006. During both January and February 2006 there were no documented refusals from the resident. 5. Interview with the director of nursing, the restorative RN (#15), and three restorative CNAs (#52, #32, and #60) on 3/9/06 at 11:25 AM revealed, that due to restorative staff absences or being pulled to the floor, sometimes residents didn't get the services as ordered.	F 353		
F 366	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by:	F 366	F366 a. The facility will ensure that each resident receives and is provided food substitutes of similar nutritive value to residents who refuse food served. b. All resident including No. 26 and 69 have been offered food and will continue to be	4-18-06

T4/5 D SH 4/21/06

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	535030	A. BUILDING _____ B. WING _____	09/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1118 LANE 12 LOVELL, WY 82431

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F 366	Continued From page 35 Based on resident and staff interview, and review of Resident Council Minutes, the facility failed to provide a substitute of similar nutritive value to resident's #26 and #65. Both residents had refused the food item served. The census at the time of survey was 72. The findings were: 1. Interview with resident #65 on 09/6/06 at 5:30 PM revealed the resident did not like spinach and requested a substitute for that vegetable. The resident stated s/he received no vegetable or comparable substitute when spinach was served as the primary vegetable. The resident voiced a preference for other vegetables to the facility staff, but continued to receive no vegetable substitute when spinach was the primary vegetable on the menu. 2. Review of resident council minutes dated 10/5/05 revealed resident #26 complained of food allergies including green peas. The minutes further stated that when the resident requested a substitute vegetable in lieu of peas, s/he received no substitute vegetable or comparable food item. 3. A confidential interview on 09/7/06 at 1:15 PM revealed 4 of 13 residents recalled one or more occasions in which they did not receive a vegetable portion when requesting a substitute to the primary menu item. 4. Interview with the dietary manager on 09/8/06 at 4:20 PM revealed an awareness of the complaints regarding lack of a vegetable substitute for specific residents. The dietary manager stated the kitchen staff "...sometimes makes mistakes..." with regard to selected substitution of vegetables.	F 366	F366 substitutes of similar nutritional value when requested. a. As of 3-28-06 the dietary staff implemented the use of food substitution book to document which residents request a different food and what foods are being replaced. d. Dietary manager will check food substitution book on a monthly basis to see that appropriate food substitutes are being used. This will serve as the CQI monitor. e. When inappropriate food substitutions are given, the Dietary manager will meet with the staff member and instruct them on appropriate food substitutes. If necessary staff inservice will be held. f. Dietary Manager will follow up on residents satisfaction of food substitutes at monthly resident council meetings or on an individual basis. To be completed by Dietary and Nursing. To be monitored by dietary, Nursing, Nursing Supervisor, D.O.N. and A.D.O.N.	4-18-06

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NEW HORIZONS CARE CENTER	1115 LANE 13 LOVELL, WY 82431

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F 371	Continued From page 36	F 371		
F 371	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prevent or correct potentially unsanitary conditions in frozen storage rooms used to maintain resident food. The findings were: Observation on 03/08/06 at 4:50 PM during the initial tour of the kitchen area revealed ice build-up in 2 of 2 walk-in freezers. a. Walk-in #3 contained a conical mass of ice measuring 2.75 inches in diameter at the top, 19.25 inches in diameter at the base, and 12.5 inches in length. The mass extended from the fan housing to a cardboard box located on the top shelf beneath the fan housing. The box, labeled "Popsicles" was partially encased in the ice. Ice was further observed on 10-12% of the total interior surface of the ceiling, side walls, back wall, and floor of walk-in #3. b. The large walk-in freezer located adjacent to the dietary manager's office exhibited ice build-up on the ceiling, fan housing, and several boxes of frozen food. The amount of ice was up to 3 inches thick in certain locations. Ice partially encased three previously opened cardboard boxes labeled "Fettuccini", "Twist Donuts", and "Soup Mix." Ice was also observed inside the soup mix box, covering several individual bags of soup mix.	F 371	F371 a. The facility will ensure that frozen foods are stored under sanitary condition. b. The two walk-in freezers in the dietary department will be cleaned and free of the build-up by 4-11-06. In addition, the boxes of food encased in ice will be discarded to prevent any food contamination. c. A CQI monitor will be put into place to ensure frozen foods are stored under sanitary conditions by having the dietary manager set up a quarterly monitor to physically look through the freezers for any deterioration of frozen foods and/or their containers. Should the need arise to remove food that has already deteriorated before the three month period, the dietary manager or one of the dietary staff will discard the affected food. Dietary Supervisor will inservice Dietary staff regarding the areas of possible ice build up. Will be monitored as needed, but no less than monthly. To be completed by Maintenance and Dietary.	4-18-06

S/S F 4/27/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	538040	A. BUILDING _____ B. WING _____	03/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1116 LANK 12 LOVELL, WY 82431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 371	Continued From page 37 2. Interview with the dietary manager on 03/08/08 at 4:20 PM revealed an awareness of the ice build-up in the walk-in freezers. The dietary manager stated she had not submitted a work order to have the situation repaired.	F 371	To be monitored by Dietary Supervisor.	
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure all medications available for resident use in two of two medication storage areas were maintained within the limits of the expiration date. The findings were: 1. Observation of the storage area for pods 2, 3, and 4 on 3/9/08 at 9:10 AM revealed the following expired medications were available for resident	F 432	F432 The facility will ensure that all medications available for resident use are maintained within the limits of the expiration date. a. Resident No. 19, 28, 54 and 56 are receiving non-expired medications. b. All residents will receive non-expired meds. All expired meds have been removed. c. Notices will be placed in medication rooms to remind nurses to check for expiration dates. Checking for expiration dates on medication was addressed in the March mandatory nurse staff meeting. d. Monthly audits will be assigned by the nurse supervisor and reported monthly as part of the facility QA program. To be completed by Nursing. To be monitored by Nursing staff, consultant pharmacist, D.O.N. and A.D.O.N.	4-18-08

DEPARTMENT OF HEALTH AND HUMA. ERVICES
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NEW HORIZONS CARE CENTER	1155 LANE 12 LOVELL WY 82431

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F 432	Continued From page 38 use: a. 38 individual packets of Ferrous Gluconate, expired 3/1/06. Registered nurse (RN) #13 confirmed the expiration date and stated the medication was used by resident #19. b. Lexapro 10 milligrams (mg), no expiration date. RN #13 stated it belonged to resident #26. c. A jar of Silvadene 1% Cream, expired 1/6/06, for resident #58. RN #13 confirmed it was used for the resident. 2. On 3/9/06 at 9:37 AM, observation of the storage area for pods 5, 6, 7, and 8 showed a tube of Formulation R hemorrhoidal cream for resident #64; the cream expired on 1/06. Interview with RN #15 during the observation confirmed the expiration date.	F 432		
F 441 S=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of policies and procedures, and review of the manufacturer's instructions, the facility failed to	F 441	F441 a. The facility will ensure proper cleaning and disinfecting of the tub and chair in a manner to prevent the spread of infection. b. The instructions for cleaning and disinfecting will be kept in each tub room for staff to refer to. c. The policy for cleaning and disinfecting has been revised. The policy will be reviewed and mandatory staff training will be provided for all CNA's assigned to do baths. This was also discussed with all staff at the March staff mtg.	04/15/06

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F 441	Continued From page 39 comply with infection control measures during one of one tub cleanings. The infection control measures were intended to prevent the transmission of potentially infectious agents. The findings were: 1. Observation on 03/7/06 at 10:10 AM showed certified nurse aide (CNA) #58 sprayed a liquid solution on the seat of a shower chair contaminated with feces. The liquid residual was wiped off the shower chair seat immediately after application. Interview with CNA #58 at the same date and time revealed the product was also used for cleaning the bathtub. The CNA further confirmed the shower chair was contaminated with feces. Review of the manufacturer's "Operating Instructions" for disinfecting the tub revealed "...disinfectants need to be left on a moist surface for 10 minutes to be effective." CNA #58 stated she waited 10 minutes when disinfecting the tub, but not when cleaning the chair. On 03/8/06 at 10:45 AM, CNA#58 stated the solution used to wipe fecal material from the shower chair seat did not require a 10 minute contact period as it was the same cleaning solution used for the tub. The CNA further stated the tub was only disinfected at the end of the day and not between each resident. The tub contained an ultraviolet (UV) light system for killing bacteria with each bath; therefore, it only needed cleaned instead of disinfected after each resident's bath. The following concerns were identified: a. Interview with CNA #58 on 03/8/06 at 7:50 AM revealed the shower chair was in the tub and submerged below the water line just prior to the observation made on 03/7/06. The CNA stated the shower chair seat was contaminated with feces when raised out of the water. Furthermore,	F 441	F411 d. Performance will be randomly monitored by QOI rounds as assigned by the Infection Control Nurse, and reported quarterly as part of the facility QA program.	4-18-06

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1119 LANE 12 LOVELL, WY 82431

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F 441	Continued From page 40 the CNA stated five residents received baths after the incident with fecal contamination was first noted. Resident #40 was the next individual to receive a bath in the contaminated tub; this resident had open wounds on the buttocks and coccyx at the time of the observation. b. Review of the label on the cleaning solution used by CNA#58 in wiping off the shower chair seat revealed it was a pre-disinfecting cleaning solution intended to enhance the UV disinfection process on the tub surface; the manufacturer's label did not indicate the solution was a disinfecting agent. CNA #58 stated on 03/9/06 at 7:50 AM that she did not routinely disinfect the bathtub after fecal contamination. c. Review of the manufacturer's "Operating Instructions," posted on the wall adjacent to the tub unit, revealed "In the event unusual matters are released into the tub (e.g. fecal matter...) consult infection control management to determine if terminal disinfection is required before using again." An additional note taped to the wall above the "Operating Instructions" conveyed the instructions, "All Bath Aides read here how to clean between baths!!" d. Interview with the assistant director of nursing (ADON) on 03/9/06 at 10:35 AM revealed the infection control policy specific to the cleaning and disinfecting of contaminated equipment was in revision. It was the ADON's stated expectation that the manufacturer's instructions for cleaning and disinfecting serve as the standard of practice for facility staff.	F 441		
F 465 88=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		

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F 465	Continued From page 41 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment for residents, staff and the public in the kitchen and on one of two resident floors. The findings were: 1. Observation of the transitional care unit (TCU) on 3/13/06 at 6:13 PM, on 3/15/06 at 1:23 PM and on 3/16/06 at 10:36 AM revealed the following concerns: a. A radio in dining room #7 was on the serving counter and plugged into an electrical outlet. The front shell of the radio was falling away from the rest of the radio body, exposing wires, circuit boards, and other electrical components. Interview with registered nurse (RN) #15 on 3/16/06 at 10:36 AM confirmed the exposed wires constituted a danger to residents if they were to stick their fingers into the radio interior. b. Several pieces of hard plaster texturing had been chipped away from the waist high window shelf above the hallway handrail across the hall from dining room #7. The exposed edges of plaster were loose enough to allow fingernails to wedge underneath and rip additional pieces of plaster away from the shelf. Interview with RN #15 on 3/16/06 at 10:36 AM confirmed the exposed plaster constituted a danger to residents if they were to pick at and dislodge plaster pieces and attempt to ingest them. c. A surge protector was lying on the floor next to the television set (TV) in the main commons area of the TCU. The TV and a video cassette recorder were plugged into the surge protector. The surge protector was plugged into	F 465	F465 The facility will ensure a safe environment for residents, staff and the public. a. The radio has been removed. The plaster has been repaired. The surge protector has been moved. b. The facility environment has been observed for further safety issues and corrections made. c. Providing and maintaining a safe environment was reviewed at the March mandatory staff meeting. d. Random rounds will be assigned by the nurse supervisor and reported monthly as part of the facility QA program. Completed by maintenance. To be monitored by maintenance, laundry/housekeeping and Nursing.	4-18-06

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F 465	Continued From page 42 an electric outlet on the wall behind the TV. The surge protector and the cords plugged into it were in the main traffic walkway and created a trip hazard. Interview with RN #12 on 3/16/06 at 10:46 AM confirmed the location of the surge protector constituted a safety hazard. 2. Observation on 03/8/06 at 5:12 PM revealed ice build up on the floor of a walk-in freezer in the kitchen area. Areas of ice build-up were 1.5 inches thick and extended onto portions of the walk-n floor where kitchen staff walked. The ice build-up represented a slip hazard to kitchen staff.	F 465	F465 a. The facility will ensure a safe environment for staff in the kitchen of the dietary department by minimizing ice build up in the walk-in freezers to prevent slip hazards. b. The two walk-in freezers in the dietary department will be cleaned and free of ice build-up by 4-11-06. c. A CQI monitor will be put into place to ensure ice build up is minimized by having the dietary manager set up a quarterly cleaning schedule for the maintenance department to "clean" the freezers by filling out a work order. d. The dietary manager will check freezers on a monthly basis for ice build-up. Should the need for removal of ice build-up arise sooner than three months, the dietary manager will fill out a maintenance work order at that time. To be completed by Maintenance and Dietary. To be monitored by Dietary Supervisor.	4-18-06
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on random observation, staff interview and review of staff meeting minutes, the facility failed to assure certified nurse aides (CNAs) performed tasks for which they were qualified and which were within their scope of practice. A CNA applied a medicated cream to sample resident #38. Furthermore, the facility failed to assure licensed nurses delegated tasks appropriately to CNAs. The findings were: 1. On 3/8/06 at 3:33 PM resident #38 complained of pain and burning around the indwelling urinary	F 492		

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NEW HORIZONS CARE CENTER	1110 LANE 12 LOVELL, WY 82431

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F 492	Continued from page 43 catheter. CNAs #56 and 76 took the resident to her room where CNA #66 obtained a tube of Vagisil Cream from the resident's drawer. Using a back to front motion, the CNA applied the cream to the resident's vaginal area and asked if it helped the "itching." The resident replied, "No," and denied pain in the urethra. The resident stated "It's right in the middle," and described the pain as "burning." The CNA replaced the tube of Vagisil Cream in the resident's drawer. The following concerns were identified: a. The CNA went from back (dirty area) to front (clear area) when applying the ointment. According to the 2004 3rd edition of "Nursing Interventions & Clinical Skills" by Elkin, Perry, and Potter, moving from a clean area to a dirty area prevents transmission of pathogenic microorganisms. b. The CNA replaced the tube of medication in the resident's drawer for future use by other non-licensed staff. c. According to the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003, applying medicated ointments is not within the scope of practice for CNAs. Further review of Chapter VII Section 6 (VI) (E) of the Nursing Practice Act revealed CNAs were responsible for "informing the delegation nurse and appropriate health professional about ability or inability to preform tasks." Interview with the director of nursing (DON) and assistant director of nursing (ADON) on 3/9/06 at 6:35 PM revealed Vagisil Cream was a medication and was usually locked in the medication cart. The DON stated they had just had a staff meeting and discussed that CNAs could not apply anything except preventive skin ointments; specifically, they could not apply medicated creams or ointments. Review of the	F 492	F492 The facility will ensure that CNA's will perform tasks within their scope of practice and the nurses will delegate tasks appropriately. a. Resident No. 38 will receive the medicated cream by licensed nurses. The cream is located in the medication cart. b. Scope of practice issues regarding CNA's applying medicated creams and powders were addressed. c. Notices will be posted in the staff report rooms to remind nursing staff that the scope of practice for CNA's related to skin care includes only skin ointments or creams that are specifically limited to preventing decubiti. This will also be discussed again in the April mandatory staff meeting. d. Performance will be monitored by the charge nurse and reported as part of the facility QA program. To be completed by Nursing. To be monitored by Charge Nurse, D.O.N. and A.D.O.N.	4-18-06

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

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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 ____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1115 LANE 12 LOVELL, WY 82431

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F 492	Continued From page 44 1/17/06 Nursing Meeting minutes verified staff were informed that only nurses could administer medications. 2. Interview with licensed practical nurse (LPN) #14 on 3/8/06 at 5 PM revealed the CNAs applied Vagasil cream for resident #38 to alleviate her discomfort. The LPN further stated the cream was kept at the resident's bedside, and it was acceptable for the CNAs to apply it. Review of the 1/17/06 Nursing Meeting Minutes revealed the following: "Prescription meds (medications) are to be given by the nurses only. CNAs should not be applying creams and powders except for Tinactin Powder. OTCs [over the counter] are okay for the CNAs to apply. Rx creams (i.e., vaginal creams and eye ointments) must be done by the nurse." Interview with the DON and ADON on 3/8/06 at 5:35 PM revealed they considered Vagisil Cream to be a medication, and the DON stated it was usually locked in the medication cart. Review of the July 2005 Nursing Practice Act and Administrative Rules and Regulations November 2003 revealed "delegation decisions must be made by the licensed nurse on the basis of the skill levels of the care givers." Further review showed the delegating nurse must delegate only those tasks which are within the CNA's "area of responsibility and scope of practice." Under "Chapter VII, Section 5. Basic Nursing Functions, Tasks, and Skills that may be Delegated (a) (ii) (F) Providing skin care including decubitus prevention" is the only task that allows CNAs to apply skin ointments or creams, and they are specifically limited to preventing decubiti (pressure sores).	F 492		