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Adult Care Licensing
and Surveys

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

PRINTED: 02/21/2013
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
	536030	B. WING	C 01/10/2013

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

CE 2/22/13

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS CNA - Certified Nursing Assistant DON - Director of Nursing eMAR - Electronic medication administration record LPN - Licensed Practical Nurse MDS - Minimum data set MAR - Medication administration record mg - Milligrams ml - Milliliter RD - Registered dietitian RN - Registered Nurse	F 000		
F 170 SS=E	483.10(l)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to deliver mail to residents on Saturdays. The findings were: During a confidential interview with 11 residents on 1/8/13 at 10 AM, the residents stated the delivery of mail on Saturday was not consistent. Interview with the activities director on 1/9/13 at 10:25 AM revealed the residents' mail was delivered to the connecting hospital Monday through Saturday at 3 PM. The activity aide who was scheduled to work Monday through Saturday picked the mail up every morning. However, the Saturday mail was not delivered to the residents until the following Monday.	F 170	To ensure residents have the right to privacy in written communication, including the right to send and promptly receive mail that is unopened. A.)All residents will receive mail six days a week. B.)Education will be provided for all activities staff about the importance of mail delivery six days a week until substantial compliance has been met. C)Monitoring of compliance will be done on Monday's to make sure mail was passed previous day. D.) Staff not following new mail	2/24/13

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

Kirk Schmoker — CNHA — 2-21-13

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.

POC accepted 2/19/13 Chapman RN ammended reviewed 2/22/13

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F 170	Continued From page 1	F 170	distribution process will receive immediate in-servicing and corrective actions will be taken. E.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure care plans were followed for 2 of 13 sample residents (#68, #70). The findings were: 1. Review of the medical record for resident #68 showed s/he had diagnoses to include rheumatoid arthritis, shoulder pain, sleep apnea and heart failure. Review of the January 2013 MAR showed the resident received a Fentanyl patch, a routine dose of oxycodone with acetaminophen twice daily and as needed for pain. The resident also received Advair and albuterol (bronchodilator). Review of the 12/6/12 care plan showed the resident was to be assessed for pain daily. In addition his/her oxygen saturations were to be monitored weekly with the vital signs. The following concerns were noted: a. Review of the medical record showed daily assessments for pain were not completed as indicated on the care plan. Review of the	F 282	The facility must ensure that the services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. A.)Daily pain assessment was added to MAR to ensure completion. Weekly oxygen saturations were taken off care plan and were no longer needed. B.)Daily pain assessment was added to MAR to ensure completion. C.)Care plans will be reviewed by primary Certified Nursing Assistant, primary nurse, and IDT quarterly. Daily changes will be made and followed by primary nurse and Certified Nursing Assistant and any other staff working with resident. D.)Education will be given to nurses and Certified Nursing Assistants to ensure care plans are updated and followed daily	2/24/13

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F 282	Continued From page 2 December 2012 MAR revealed pain assessments were completed 7 of 31 days and in January 2013, they were completed 3 of 7 days. b. Weekly oxygen saturations were not documented weekly. Review of the vital sign sheets showed they were documented as completed twice in October 2012, no saturations were documented in November 2012, and only once in December 2012. 2. Review of the medical record for resident #70 showed s/he had diagnoses to include osteoarthritis. Review of the January 2013 MAR showed the resident received oxycodone with acetaminophen routinely four times daily for pain and an order for additional pain medication as needed. Review of the 11/13/12 care plan showed the resident was to be assessed for pain daily. Review of the January 2013, December and November 2012 MARs showed pain assessments were documented when the resident received additional pain medication only. 3. Interview with the restorative manager on 1/10/13 at 9:30 AM revealed pain assessments were completed only when the residents requested additional pain medication. In addition, she was not able to provide any additional documentation for oxygen saturations for resident #68.	F 282	to provide quality care. E.)Monitoring of compliance will be done weekly by random reviews of two care plans per week by supervisors using the quality improvement monitoring tool, until substantial compliance has been met. F.)Staff not updating or following care plans will receive immediate in-servicing and corrective actions will be taken. G.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		2/24/13

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F 312	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of the facility's policies and procedures, the facility failed to ensure appropriate perineal care was provided during 1 of 5 observations of incontinence care affecting sample resident #63. The findings were: 1. During an observation on 1/8/13 at 9:45 AM CNA#1 provided perineal care to resident #63. The CNA removed the resident's wet incontinence pad while s/he was in a sit to stand lift. The following concerns were identified: a. The CNA cleansed the resident's anterior perineum but did not include the upper thighs or posterior perineum where urine had come in contact with the skin. Review of the 11/21/12 significant change MDS assessment showed the resident was totally dependent for personal hygiene and toilet use. b. Interview with the CNA on 1/10/13 at 8:15 AM revealed it had been "awhile" since her training related to incontinence care, and was only to cleanse the resident where s/he was soiled. 2. Review of the policy and procedure for perineal care last reviewed on 9/4/11 showed both the anterior and posterior perineum were to be cleansed "... to provide cleanliness and comfort to the resident, to prevent infections and skin irritation..."	F 312	The facility will ensure all residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A.)The facility will ensure appropriate perineal care is performed for resident #63 and all residents. B.)Education will be provided to all staff on the importance of providing appropriate perineal care to all residents. C.)Monitoring of compliance will be done by weekly random rounds observing pericare for two residents using the quality monitoring tool by charge nurses until substantial compliance has been met. D.)Staff not providing appropriate pericare will receive immediate in-servicing and corrective actions will be taken. E.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		2/24/13

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F 323	Continued From page 4 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and procedures, the facility failed to ensure 1 of 4 medication carts was locked (secure area medication cart) when staff was not present. In addition, the facility failed to ensure unsafe chemical solutions were secured in one area (secure unit) during random observations. The findings were: 1. An observation of medication administration on the secured unit by RN #3 on 1/8/13 revealed the following concerns: a. Observation at 5:22 PM showed RN #3 prepared medications for administration at the medication cart. The cart was left unlocked while the RN walked away from the cart with her back toward the cart in the dining area to give a resident their medication. b. An observation at 5:25 PM showed the RN prepared medication at the cart, left the cart unlocked and walked away from the cart with her back toward the cart. The RN walked 3 tables away and gave a resident their medication. At 5:26 PM two residents were observed walking between the cart and the RN to their seats in the dining area while the RN's back was turned away from the cart while giving a resident medication.	F 323	The facility will ensure that the resident environment remains as free of accident hazards as is possible and that each resident received adequate supervision and assistance devices to prevent accidents. A.)All medication carts will remain locked when staff are not present. Unsafe chemical solutions will be secured in all areas during random observations. B.)Education will be provided to all nurses on the importance of keeping medications locked at all times when not present. Education will be provided to all staff on the importance of keeping unsafe chemical secured in all areas. C.)Monitoring of compliance will be done by weekly random observations and physical checks of two medication carts per week and four resident areas per week by supervisors for unsafe chemicals using the quality improvement monitoring tool until substantial compliance has been met. D.)Nurses not locking medication carts and staff not keeping unsafe chemicals	

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F 323	Continued From page 5 c. At 5:35 PM the RN prepared an as needed (PRN) medication for a resident who she stated had become,"more verbally agitated over the past hour." The RN walked away from the unlocked cart with her back toward the cart, gave the resident his/her medication, leaned down and talked with the resident for several minutes. During this time a resident walked by the unlocked medication cart. d. An interview with the RN on 1/8/13 at 5:37 PM revealed she routinely left the medication cart unlocked in the dining area because she was in the same room. e. An interview with the DON on 1/8/13 at 6:30 PM revealed she expected nurses to lock the medication cart if the medication cart was not visible to them. The DON also revealed this is the facility's policy. 2. Review of the facility's policy titled,"Specific Medication Administration Procedures A: Medication cart is locked at all times unless in use and under the direct observation of the medication nurse/aide."	F 323	secured will receive immediate in-servicing and corrective actions will be taken. E.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	
	3. During observations on 1/7/13 at 9 PM, 1/8/13 at 9:30 AM, and 1/9/13 at 10:30 AM, a one quart spray bottle of HB Quat solution (ammonia) was observed in an unlocked room (Employee Break Room #3255) under the sink in the secure unit. Periodic observations during the survey revealed residents ambulated past the unlocked room without staff present. Interview with the ICC (Infection Control Corrdinator) on 1/9/13 at 3:20 PM acknowledged the disinfectant found under the sink in the secure unit was unsafe.			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		2/24/13

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F 325	Continued From page 6 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, and medical record review, the facility failed to monitor weight loss interventions for 1 of 7 residents (#71) reviewed for weight loss. The findings were: Medical record review showed resident #71 was admitted to the facility on 6/7/06 with diagnoses including diabetes, non-Alzheimer's dementia, hypertension, and anxiety disorder. A review of the MDS significant change assessment dated 10/12/12 showed the resident was cognitively impaired, required assistance with activities of daily living including eating, and had no significant change in his/her weight. A review of the care area assessment revealed no triggers for weight loss. A review of a facility form titled,"Nutrition Risk Assessment", showed on 7/3/12, 9/27/12 and 10/11/12 the resident was at high risk for weight loss. An RD note dated 9/27/12 showed the resident was supposed to receive glucerna (a liquid meal supplement for individuals with	F 325	The facility will ensure that all residents will maintain acceptable parameters of nutritional status unless the residents clinical condition demonstrates that this is not possible; and (2) receives a therapeutic diet when there is a nutritional problem. A.)The facility will ensure monitoring of weight loss interventions are completed for resident #71 and all other residents. B.)Glucerna three times daily and multi-vitamin daily are listed on resident #71 care plan. Resident #71 has been re-weighed. C.)Registered Dietitian will notify MDS Coordinator and Certified Dietary Manager of significant weight loss changes in one, three, and/or six months via nutrition therapy intervention as needed. D.)R.D. will note nutrition supplementation onto resident #71 interdisciplinary care	

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F 325	Continued From page 7 diabetes) three times daily with meals and a multi-vitamin. The care plan updated on 10/16/12 showed under eating that the resident liked meals on a tray, had been ordered an 1800 calorie diabetic diet, had his/her natural teeth, encourage to eat related to a poor appetite, and to feed the resident as needed. A care plan for alteration in behavior related to dementia and refusing meals had interventions that included encouraging the resident to come out for meals and offering supplements if the resident refused meals, however, the glucerna three times daily with meals and the multi-vitamin daily were not listed on the residents care plan. The following concerns were identified: a. The resident was observed at breakfast on 1/8/13 at 8:30 AM. The tray card indicated the resident received an 1600 calorie diabetic diet, there was no glucerna listed on the tray card or on the resident's breakfast tray. The resident was observed at the supper meal on 1/9/13 at 5:30 PM. Glucerna was on the resident's tray and it was opened, however, the resident did not consume any of the supplement. Glucerna was not listed on the tray card. b. The resident's weight in June 2012 was 156 lbs (pounds) and December 2012 was 132 lbs, with a weight loss was 24lbs or 15% over 6 months. An RD note dated 11/19/12 showed the resident's weight was 143 lbs and the resident had experienced a significant change in weight over 3 months, and noted that the resident's intakes continued to decline. The RD recorded,"will send breakfast foods for all meals and see if this helps increase intake". The RD note dated 12/13/12 showed the resident's weight was questionably recorded at 132 lbs per staff reporting the resident had been eating more,	F 326	plan as well as nursing 24 hour report. E.)RN/LPN will in turn note the nutrition supplement consumption separate from other fluids consumed by the resident. F.)R.D. will notify CDM via dietary intervention form to add nutrition supplement to dietary card of resident #71. G.)Consumption of liquid nutrition supplements will be recorded by nursing staff in the treatment administration record for resident #71 and residents who are at high risk for weight loss. H.)Education will be provided to all nursing staff on the importance of recording nutrition supplements in the TAR. I)Monitoring of compliance will be done by weekly random checks of the TARS for two residents at high risk for weight loss by nursing supervisors using the quality improvement monitoring tool until substantial compliance has been met. J.)Nursing staff not compliant with recording nutritional supplements for residents at high risk for weight loss will receive immediate in-servicing and corrective actions will be taken. K.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	

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F 325	Continued From page 8 however the resident was not re-weighed. The documentation on the RD notes dated 11/19/12 and 12/13/12 did not indicate whether the resident should continue to receive glucerna three times daily with meals. c. A multi-vitamin was ordered on 2/5/12 and a review of the MAR indicated the resident was taking the vitamin daily. The order for the multi-vitamin ended on 10/20/12 per the MAR and no indication was given why the multi-vitamin was discontinued. Review of the MAR and treatment administration record also revealed no order for glucerna supplements three times daily with meals. d. Review of a physician progress note dated 9/26/12 showed the resident,"presents with evaluation for not eating very well per nurses." The note showed the resident,"feels fine but that [s/he] does not feel like eating and is eating a small amount if any at all". Diagnoses included failure to thrive;"pt [patient] is not eating [S/he] states [s/he] feels fine but not hungry, denies pain and that etiology unknown. "The plan was, ..."encouraged pt to eat, mood seems ok, monitor status closely, continue meds." Review of physician recertification examination dated 1/3/13 showed "staff is concerned that [s/he] has recently had a very poor appetite with weight loss..." We will review [his/her] medication and continue to care for [him/her] in the care center. We will also order labs to follow up on [his/her] general health. Patient is in agreement with this plan". e. Review of nursing notes dated 9/29/12 through 1/9/13 revealed 23 entries where the resident refused meals or had a decreased appetite. Review of the intake and output records from 10/1/12 through 1/9/13 showed the resident	F 325		

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F 325	Continued From page 9 consumed less than 50% of 2 of 3 meals offered and did not indicate whether glucerna was offered or the amount consumed. f. Review of labs dated 10/17/12 showed a low albumin level of 2.90 gm/dL (grams per deciliter). Normal albumin levels range from 3.60 to 5.20 gm/dL. (Albumin is a protein found in blood that is formed in the liver and is used as a beginning measure to assess nutrition). g. An interview with the resident's responsible party on 1/8/13 at 2:30 PM revealed concerns related to weight loss. h. An interview with CNA #2 on 1/8/13 at 2 PM revealed nutritional supplements including glucerna were documented on the meals and fluids report as part of the total fluid intake. i. An interview with the RD on 1/9/13 at 9:30 AM revealed the resident was supposed to receive glucerna 3 times a day with meals. The RD also revealed that glucerna was not recorded on the MAR or treatment administration record but was recorded as part of the total fluid intake by the CNA's. Therefore, there was no accurate way to determine whether the resident was consuming the glucerna. The RD indicated interventions were attempted such as breakfast foods at each meal, glucerna three times daily with meals and the resident has "snacks in his/her room including nuts and sugary snacks". j. An interview with the dietary manager (DM) on 1/10/13 at 12:30 PM verified the glucerna intake was recorded as fluid intake and she was not sure how much glucerna the resident was actually consuming, unless the can of glucerna came back unopened on the resident's meal tray or the CNA's informed her that the resident had not consumed the glucerna. The DM revealed the glucerna was supposed to be listed	F 325		

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F 325	Continued From page 10 on the resident's tray card. The DM was aware that the resident had lost weight and mentioned interventions including glucerna supplements three times daily with meals. She further stated that the resident,"ate the breakfast foods for every meal really well for a while but gets tired of something and will not eat it anymore. The weight of 132 lbs in December 2012 was low and the resident should have been re-weighed." The DM had no explanation why the resident was not re-weighed in December 2012.	F 325		
F 332 SS=E	483.26(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to maintain an error rate under 5%. Five errors occurred out of 64 opportunities resulting in an error rate of 7.8 %. The findings were: 1. During a medication pass on 1/8/13 at 5:05 PM, LPN #1 administered non-sample resident #2 albuterol 2.5 mg in 3 ml of solution by way of a nebulizer. The following concerns were identified: a. Review of the 11/5/12 physician orders showed albuterol nebulizer 1.25 mg/3 ml to be given as needed. Further review showed an additional order for albuterol 2.5 mg to be given as needed every two hours. b. Interview with the LPN on 1/8/13 at 6:25 PM verified the order for albuterol showed the	F 332	The facility will ensure that it is free of medication error rates of five percent or greater. A.)The facility will ensure medications are administered correctly according to physician's orders for residents #2, #3, #60, and #62 and all other residents. B.)MARS for resident #2 has been corrected reflect the correct order. Resident #3 is receiving the correct dose of glucosamine 500 mg and chondroitin 400 mg three times daily per physician orders. Resident #62 is receiving glimepride 4 mg at bedtime per physicians orders. Resident #60 is receiving Zocor 20 mg and Famotidine 20 mg per physician orders.	2/24/13

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F 332	Continued From page 11 medication was to be given as needed and not routinely and the MAR did not reflect the correct order. 2. During a medication pass on 1/8/13 at 5:35 PM showed LPN #1 gave glucosamine 1500 mg and chondroitin 1200 mg to non-sample resident #3 from the stock medication supply. Review of the 11/20/12 physician orders showed the resident was to receive glucosamine 500 mg and chondroitin 400 mg three times daily. During an interview and review of the MAR and physician orders with the LPN on 1/8/13 at 6:25 PM, she verified the resident received the incorrect dose. 3. During a medication pass on 1/9/13 at 8 AM LPN #2 gave sample resident #62 glimepiride 4 mg. Review of the 1/3/13 physician orders showed the resident was to receive the medication at hs (bedtime). During an interview with the LPN on 1/9/13 at 2:40 PM she stated the eMAR used at the time of the medication pass showed the medication was to be given in the morning. Review of the printed MAR showed the medication was to be given at bedtime and the nurse gave the dose in the morning. 4. During a medication pass on 1/8/13 at 5:15 PM LPN #3 administered the medication for resident #60 including Zocor 20 mg and Famotidine 20 mg. The following concerns were identified: a. Recapitulation of physician orders showed the resident was supposed to receive Zocor 20 mg at bedtime and Famotidine 20 mg at bedtime. b. Interview with LPN #3 on 1/9/13 at 6:15 PM verified the resident's Zocor and Famotidine were supposed to be given at bedtime, not at the 5 PM medication pass.	F 332	C.)Education will be provided to all nurses on the importance of administering medications correctly according to physician's orders to ensure the facility's medication error rate is less than 5%. MARS for resident #2 has been corrected to reflect the correct order. Resident #3 is receiving the correct dose of glucosamine 500 mg plus chondroitin 400 mg three times daily per physician orders. Resident #62 is receiving glimeperide 4 mg, at bedtime per physician orders. Resident #60 is receiving Zocor 20 mg and Famotidine 20 mg. per physician orders. A frequency order for albuterol nebulizer treatment 1.25/3ml, for resident #2 has been added and the MAR will reflect the correct most current physician orders. D.)Monitoring of compliance will be done by weekly random observation of two nurses by supervisors using the quality improvement monitoring tool to ensure the facility medication error rate is less than 5%. E.)Nurses not administering medications without medication errors will receive immediate in-servicing and corrective actions will be taken. F.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	

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F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the electronic medication system was free of significant errors for non-sample residents #2, #4, #5, #6 and sample residents #60 and #70 with the potential to affect all residents. The facility had a census of 73 at the time of the survey. The findings were: 1. During a medication pass on 1/8/13 at 5:05 PM LPN #1 administered resident #2 albuterol 2.5 mg in 3 ml of solution by way of a nebulizer. The	F 425	The facility will ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) are provided to meet the needs of each resident. A.)The facility will ensure the electronic medications system is free of significant errors for residents #2, #4, #5, #6, #60, #70 and all other residents. B.)A frequency order for albuterol nebulizer treatment 1.25/3ml. for resident	2/24/13

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F 425	Continued From page 13 following concerns were identified: a. Review of the 11/5/12 physician orders showed albuterol nebulizer treatment 1.25 mg/3 ml to be given as needed. No frequency was noted. Further review showed an additional order for albuterol 2.5 mg to be given as needed every two hours. There were no routine doses of the medication ordered. b. Review of the printed January 2013 eMAR showed the resident was to receive albuterol 2.5 mg three times daily and as needed. c. Review of the 9/11/12 physician orders showed the resident was ordered albuterol 1.25 mg neb (nebulizer) treatments four times daily. In addition, the resident was ordered albuterol 2.5 mg every two hours as needed. d. Review of the physician orders dated 10/2/12 showed the albuterol treatment frequency changed to be given three times daily. The dose of 1.25 mg did not change. e. Interview with the LPN on 1/8/13 at 6:25 PM verified the order for albuterol showed the medication was to be given as needed and not routinely. In addition, the LPN verified the MAR did not reflect the most current physician orders. 2. An interview with RN #1 on 1/8/13 at 8:35 AM revealed the medication onglyza was discontinued approximately one month ago for non-sample resident #4. Review of the January 2013 eMAR with the RN showed it was to be given on 1/6 and 1/7/13. The RN attempted to notify the pharmacy about the error but did not receive a response. Review of the physician orders dated 11/8/12 showed the medication had been discontinued. 3. Review of the printed January 2013 eMAR for	F 425	#2 has been added and the MAR will reflect the correct most current physicians orders. January 2013 eMAR for resident #70 includes the amount of albuterol the resident receives. The eMAR for SennaS 2 tablets for resident #5 has been corrected to reflect the current physician order. The eMAR for Ditropan ER 10 mg for resident #6 has been corrected to reflect the current physician order. C.)Education will be provided to all nurses on the importance of ensuring the electronic medication system is free of significant errors for all residents. D.)Monitoring of compliance will be done by weekly random checks of two residents orders against the MAR by supervisors using the quality improvement monitoring tool. E.)Nurses not ensuring the electronic medication system is free of significant errors will receive immediate in-servicing and corrective actions will be taken. F.)Results will be reported quarterly at the quality meeting as part of the facility assurance program.	

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F 426	Continued From page 14 resident #70 showed s/he was to receive a nebulizer treatment of albuterol 0.5-3 mg four times daily. The MAR did not indicate the dose of medication to be given, it only showed a dose range. Further review of the MAR did not indicate how much of the medication the resident received with each treatment. 4. Observation on 1/8/13 at 5:15 PM showed LPN #3 prepared and gave resident #60 Zocor 20 mg and Famotidine 20 mg. Review of the pharmacy order dated 12/28/12 for Zocor 20 mg and Famotidine 20 mg dated 12/8/12 showed the medications were supposed to be given at bedtime. Review of the printed eMAR received 1/9/13 at 8:40 AM revealed Zocor and Famotidine were ordered at bedtime and in parenthesis late PM, it also indicated the last dose was given at 5:17 PM on 1/8/13. 5. Observation on 1/9/13 at 5:50 PM showed LPN #3 prepared Senna S 2 tablets for non-sample resident #5. The LPN noted that the eMAR showed 2 different times for the medication to be administered, at bedtime and late PM. The LPN indicated an order clarification should be obtained and did not give the medication, however, she indicated that a review of the eMAR indicated the Senna S had been given daily at 5 PM. Review of the physician's order dated 11/7/11 showed the resident was supposed to receive Senna S 2 tablets at bedtime. Observation of the eMAR during medication pass revealed the medication was ordered to be given at bedtime and in the paragraph below showed, "give in late PM". The last dose of Senna S was given on 1/8/13 during the 5 PM medication pass.	F 425		

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F 425	Continued From page 15 6. Observation on 1/9/13 at 6:10 PM showed LPN #3 prepared Ditropan ER 10 mg for administration to non-sample resident #6. The LPN noticed the eMAR showed 2 different times for the medication to be administered, at bedtime and late PM. The LPN did not give the Ditropan ER and indicated that a clarification order should be obtained prior to administering the medication. The LPN reviewed the eMAR and revealed the Ditropan ER had been given daily at 5 PM. Review of the physician's order dated 12/20/12 showed the resident was supposed to receive Ditropan ER 10 mg at bedtime. Review of the eMAR during the medication pass revealed the medication was ordered to be given at bedtime and in the paragraph below instructions showed, "give in late PM", with the last dose of Ditropan ER given on 1/8/13 during the 5 PM medication pass. 7. Interview with the DON on 1/9/13 at 4:30 PM revealed the facility had problems with the eMAR. She stated for example, medications that had been discontinued would reappear on the eMAR days later to be given without a physician's order. She further stated nurses who were not familiar with the residents could give a medication that was incorrect. An interview with the DON at 5:45 PM that same day revealed nurses administering medications were educated to notify the pharmacy if they found errors on the eMAR. In addition, the nurses were to change the MAR to reflect the correct medication order. She stated the problem was initially identified on 12/20/12. 8. Review of an e-mail record by the DON from the pharmacy on 1/9/13 timed 6:29 PM showed it stated they had identified "inconsistencies and	F 425		

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F 425	Continued From page 16 problems related to the eMAR." Problems included: "pharmacy input inconsistency, inconsistent procedures related to medication reconciliation from Pharmacy orders and Nursing, and inconsistent application of the program by nursing." The email further stated the pharmacy staff would be in-serviced sometime the week of 1/14/13 on the problems identified. 9. Interview with the pharmacist on 1/10/13 at 11:40 AM via telephone revealed there had been an internal software upgrade that was to only affect the pharmacy itself but unexpectedly affected the facilities the pharmacy serviced. He further stated he was uncertain when the problems associated with the upgrade would be fixed.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		2/24/13

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F 431	Continued From page 17 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 ensure that expired medications were not available for resident administration in 2 of 2 medication rooms and 4 of 4 medication carts. The findings were: 1. Observation of the medication room on the second floor on 1/10/13 at 8:10 AM revealed stock ipratroplum bromide nasal spray had expired 9/1/12. 2. Observation of the medication room on the first floor on 1/10/13 at 8:30 AM revealed 2 ear drop bottles expired 12/12; oxybutynin 5 mg expired 10/12 for non-sample resident #7; potassium chloride 10 meq (milliequivalents) expired 10/2/12 for resident #7; sulfamethoxazole DS expired 9/11/12 for non-sample resident #8; stock Extra Strength Stool Softener expired on 10/12; and stock Ester-C 1000 mg expired 12/12.	F 431	The facility will ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. A.)The facility will ensure expired medications are not available for use for residents, #7, #8, #9, #10, #11, #5, #12, #13, #14, #15 and all other residents. B.)Expired medications have been removed from both medication rooms. C.)Education will be provided to all nurses on the importance of checking expiration dates of all medication to ensure they are not available for resident use. D.)Monitoring of compliance will be done by weekly random checking of two medication carts and one medication	

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F 431	Continued From page 18 3. Observation of the medication cart for pods 3 and 4 on 1/10/13 at 9 AM revealed promethasine 25 mg had expired 12/20/12 for non-sample resident #9. 4. Observation of the medication cart for pod 2 on 1/10/13 at 9:10 AM revealed Benadryl-Maalox-Lidocaine oral suspension had no expiration date for non-sample resident #10. 5. Observation of the medication cart for the second floor on 1/10/13 at 9:40 AM revealed simvastatin 20 mg had expired 12/12 for non-sample resident #11. 6. Observation of the medication cart for the secure unit on 1/10/13 at 9:50 AM revealed nystatin oral suspension had no expiration date for non-sample resident #5; 2 bottles of ChlorBeta-Maalox-Vaseline oral suspension had expired on 11/1/12 and on 12/27/12 for non-sample resident #12; tolnaftate anti-fungal powder 1% expired 11/12 for non-sample resident #13; tolnaftate anti-fungal powder 1% expired 11/12 for non-sample resident #14; ipratropium albuterol expired 11/12 for non-sample resident #15. Interview with RN #2 on 1/10/13 at 9 AM revealed the medication nurses checked the carts for expired medications every week as part of their medication administration, and that she was responsible for checking expired medications for the second floor medication room and RN #4 was responsible for the first floor medication room. The RN further verified the above medications were expired and available for resident use.	F 431	room cupboard by a nursing supervisor using the quality improvement monitoring tool until substantial compliance has been met. E.)Nurses not ensuring expired medications are not available in their assigned area will receive immediate in-servicing and corrective actions will be taken. F.)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD; LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		2/24/13

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F 441	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the facility's policy and procedures, the facility failed to ensure staff cleansed their hands appropriately during 4 random observations and hand sanitizers were not expired and available for use in 3 areas of the facility. In addition, the facility failed to ensure laundry was monitored for infection control. The findings were: 1. Observation on 1/8/13 at 9:30 AM showed LPN #2 changed the colostomy (an opening of a portion of the colon through the abdominal wall) bag for resident #63 with gloved hands. She then removed her gloves and donned a second pair of gloves without first washing her hands. The LPN continued to redress the resident's fistula (opening between the colon and the skin surface) located on his/her abdomen. 2. Observation on 1/8/13 at 9:45 AM showed CNA #2 completed incontinence care for resident #63 with gloved hands. She then placed the oxygen tubing on the resident and removed the resident's comb from the drawer. The CNA then removed her gloves and donned a second pair without first cleansing her hands. She continued to assist the resident to adjust his/her pillows and blankets. 3. Observation on 1/8/13 at 9 AM showed CNA #3 completed incontinence care for resident #64 with gloved hands. The CNA removed her gloves and finished dressing the resident in the wheelchair without first cleansing her hands. 4. Observation on 1/8/13 at 9:30 AM showed CNA	F 441	The facility will ensure there is in place an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will ensure staff cleanse their hands appropriately during cares provided for residents #63, #64, and #65 and all other residents. The facility will ensure there are no expired hand sanitizers in the facility and that water temperatures are being monitored in the laundry room. B.)Expired hand sanitizer in staff break room on the secured unit and activity room on the first floor have been removed. C.)Water temperatures in laundry will be monitored and documented daily by laundry aides. D.)The facility will install a hot water circulator to maintain hot water temperature and a gauge to monitor temperatures on the new washer. E.)Specifications have been obtained from Ecolab, who will check the parts per million monthly and record it on their report. F.)In-service was provided to laundry aides on checking laundry temperatures on 01/23/13. In-service will be provided to all laundry aides on new washer after installation. G.)Monitoring of compliance of laundry temperature will be done by weekly	

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	536030	A. BUILDING _____ B. WING _____	C 01/10/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 #3 completed incontinence care for resident #65 with gloved hands. The CNA removed her gloves and finished dressing the resident without first cleansing her hands. Interview with CNA #4 on 1/9/13 at 1:50 PM revealed she washed her hands only after removing her gloves and before donning a second pair if the first pair of gloves had been soiled. Interview with CNA #1 on 1/10/13 at 8:15 AM revealed she was instructed to wash her hands only after she removed her gloves and before exiting the resident's room. Interview with CNA #3 on 1/8/13 at 9:40 AM revealed she knew she should have washed her hands after removing the gloves but "just forgot". 5. Observation on 1/7/13 at 8:30 PM showed the hand sanitizer in the staff break room located on the secure unit expired in April 2009. On 1/10/13 at 9 AM the hand sanitizer located in the activity room on the first floor was found to have an expiration date of April 2010. The date on the hand sanitizer in the activity room was verified by the activities aide #1 at that time. 6. Observation on 1/10/13 at 9:50 AM showed the hand sanitizer in the office on the secure unit had expired 2/12. Interview with RN #3 at that time verified the expiration date. 7. An interview with the infection control nurse on 1/9/13 at 3:20 PM acknowledged staff were to wash their hands after removing gloves and before continuing resident care. In addition, hands were to be washed before donning a second pair of gloves. Further, the hand sanitizers should not be available for use after	F 441	random checking of all laundry water temperature logs by the laundry supervisor using the quality monitoring tool until substantial compliance has been met compliance. H.)Education will be provided to all nursing staff, regarding the importance of hand washing during cares and removing expired hand sanitizers. I.)Monitoring of hand washing during cares will be done by weekly random observation of cares being provided to two residents by supervisors until substantial compliance has been met. Monitoring of hand sanitizers will be done by weekly random rounds checking expiration dates of three sanitizers using the quality improvement monitoring tool until substantial compliance has been met. J.)Laundry aides not monitoring water temperatures, nursing staff not performing appropriate hand hygiene during cares and not removing expired hand sanitizers, will receive immediate in-servicing and correction actions will be taken. K.)Results will be reported quarterly at the quality meetings as part of the facility quality assurance program.	

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CF 2/22/13

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F 441	Continued From page 22 they have expired. 8. Interview on 1/9/13 at 3:55 PM with housekeeper #1 she did not know how to check the washing machine temperatures. The following concerns were identified: a. During an interview with the housekeeping manager on 1/10/13 at 8:20 AM she acknowledged that staff, " ...used to record the actual water temperatures of the washing machines but they stopped doing that about a year and a half ago because the laundry staff were not doing it correctly and the temperatures were all over the place." The housekeeping manager also stated, "the facility got a new washing machine about a year ago and neither she nor her staff were aware of how to monitor the temperature on the new machine. She indicated that the laundry serves both the long term care and the hospital. She also stated that a chemical additive was added to the wash cycle and this service was contracted through a commercial vendor (Ecolab). She was unaware of the specifications of the laundry additives provided by Ecolab (minimum water temperature or effective residual concentration) and was unable to provide those specifications upon request. b. Observation of washing machine water temperatures during a wash cycle on 1/10/13 at 8:30 AM showed a water temperature of 111 degrees Fahrenheit for washing machine #1. Observation of washing machine water temperature during a wash cycle on 1/10/13 at 10:55 AM showed a water temperature of 109 degrees Fahrenheit for washing machine #2. Washing machine #3 was the newest machine bought by the facility and was noted that neither	F 441		

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

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F 441	Continued From page 23 the supervisor nor the staff knew how to measure water temperatures on the new machine. A temperature above 160 degrees Fahrenheit is required to destroy micro-organisms by water temperature. c. Interview with the housekeeping manager on 1/10/13 at 11:10 AM confirmed she was not aware of the minimum specifications for water temperature and effective residual concentrations. d. Interview with the infection control nurse on 1/10/13 at 11:15 AM revealed she was not aware of the standards or guidelines appropriate for laundry services. The infection control nurse indicated monitoring of water temperatures was the housekeeping supervisor's responsibility. e. Interview with the human resources (HR) director on 1/22/13 at 1:20 PM revealed she had managerial authority over housekeeping and the laundry. She was unaware the laundry/housekeeping staff were unable to determine actual water temperatures for the washing machines until 1/10/13.	F 441		