PRINTED: 02/28/2014
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 _____	02/13/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse UTI- Urinary Tract Infection Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive 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 purpose 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 medical record review and staff interview, the facility failed to complete a	F 274	The facility will conduct comprehensive assessments on a resident within 14 days after the facility has determined that there has been a significant change in the resident's physical or mental condition. A)The facility will ensure a significant change MDS assessment is completed for resident #17 and all residents. B)The facility has implemented new significant change in status forms and change of condition guidelines to ensure an accurate MDS. C)Education will be provided to the interdisciplinary team and to all staff on what a significant change in condition is and how to report a significant change.	03/30/14

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WY Dept. of Health
MAR 10 2014
Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Schroeder	LHHA	3-6-14

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.

OVER

3/18/14

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F 274	Continued From page 1 significant change MDS assessment for 1 of 5 sample residents (#17) who required that type of assessment. The findings were: Review of the 9/19/13 initial MDS assessment showed resident #17 required limited assistance for transfers and dressing, and had no falls. A comparison of the subsequent quarterly MDS assessment, dated 12/17/13, revealed the resident declined, and required extensive assistance in transfers and dressing. In addition, the resident fell twice since the previous assessment. During an interview on 2/12/14 at 3 PM, the MDS coordinator stated the quarterly MDS assessment should have been a significant change assessment due to the resident's decline in two or more areas. According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0, October 2013, a significant change assessment is appropriate "...with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)."	F 274	D)Monitoring of compliance will be done by weekly random review of the 24 hour report forms and M.D. communication list using the quality improvement monitoring tool by supervisors until substantial compliance has been met. E)Results will be reported quarterly as part of the facility quality assurance program.	03/30/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	The facility will develop a comprehensive care plan for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, mental, and psycho social needs that are identified in the comprehensive assessment.	03/30/14

3/18/14 - This POC accepted with agreed to changes between CEO Rick Schrader and Tony Wallace, Surveyor.

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F 279	Continued From page 2 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a care plan based on the comprehensive assessment for 1 of 15 sample residents (#24). The findings were: Review of the 9/30/13 annual MDS assessment for resident #24 revealed dehydration triggered (required further assessment). According to the 9/30/13 CAA, the facility was going to care plan for dehydration risk. However, review of the care plan (last updated 1/16/14) showed dehydration was not addressed. During an interview on 2/13/14 at 3 PM the MDS coordinator confirmed dehydration was not addressed, but should have been.	F 279	A)The facility will care plan the trigger of dehydration for resident #24. B)Care plans will be reviewed and updated by the interdisciplinary team quarterly. Daily changes will be made by the charge nurse and C.N.A. and any other staff working with the resident. C)Education will be provided to the interdisciplinary team and dietitian to ensure care plans and care area assessments coincide. D)Monitoring of compliance will be done by random weekly reviews of two care plans by the MDS coordinator using the quality improvement monitoring tool until substantial compliance has been met. E)Results will be reported quarterly at the quality meeting as part of the facility quality assurance program.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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F 280	Continued From page 3 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the written care plan was updated to reflect current status for 3 of 15 (#16, #17, #79) sample residents. The findings were: 1. Review of the medical record for resident #16 showed a 12/5/13 note from the registered dietitian (RD) for weight loss interventions which included "record weekly weight" and a 12/6/13 physician order for staff to obtain weekly weights. Review of the resident's weights showed the resident was weighed twice in December 2013, twice in January 2014, and twice in February 2014 to the date of survey of 2/10/14. Review of the resident's care plan revealed a 9/9/13 plan that addressed significant weight loss with interventions. However, the facility failed to update the care plan to include weekly weights. Interview with the DON on 2/12/14 at 4:20 PM confirmed the facility failed to update the care plan for resident #16 to include weekly weights.	F 280	The facility will ensure a comprehensive care plan is developed for residents #16, #17 and #79 and all other residents within seven days after the completion of the comprehensive assessment prepared by the interdisciplinary team. A)Resident #16 will receive dietitian evaluation to determine the need for continued weekly weights. B)The current care plan for residents #17 and #79 will be updated to reflect their current urinary tract infections. C)Care plans will be reviewed by the interdisciplinary team quarterly. Daily changes will be made and followed by the primary nurse and C.N.A. and any other staff working with the resident. D)Education will be provided to all staff and the interdisciplinary team on the importance of ensuring care plans are updated daily in order to provide quality care.	03/30/14

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F 280	Continued From page 4 2. Review of the medical record showed resident #17 had diagnoses including recurrent UTIs. Review of physician orders showed the resident was started on an antibiotic on 2/5/14 for a UTI. Review of nursing notes showed the resident also had a UTI in December 2013 and January 2014. However, review of the care plan (last updated 2/10/14) showed UTIs were not addressed. On 2/12/14 at 3 PM, the MDS coordinator stated interventions for the resident's frequent UTIs should have been on the care plan, but were not. 3. Review of the medical record showed resident #79 was admitted to the facility on 4/24/13 with diagnoses including UTI. Review of the significant change MDS assessment dated 1/28/14 showed the resident was severely cognitively impaired, and was incontinent of urine. Review of the care plan updated on 1/28/14 showed the resident required assistance with ADLs. Interventions included staff assisting the resident with toileting every 2-3 hours and providing perineal care after incontinent episodes. Review of the medical record showed the resident had been diagnosed with UTIs on 10/9/13, 11/25/13, 12/28/13, and 1/6/14. A urine culture dated 1/17/14 also showed the resident was infected with methicillin-resistant staphylococcus aureus (MRSA). The care plan was not updated to reflect the resident's recurrent UTIs. Interview with the MDS coordinator on 2/12/14 at 3:05 PM verified the care plan should have been updated with interventions that reflected his/her recurrent UTIs.	F 280	E)Monitoring of compliance will be done by weekly random review of two care plans by the MDS coordinator using the quality improvement monitoring tool until substantial compliance has been met. F)Staff not updating care plans will receive immediate in-service and corrective action will be taken. G)Results will be reported quarterly as part of the facility quality assurance program.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	A)The facility will ensure necessary care and services are provided to	03/30/14

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F 309	Continued From page 5 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure insulin was administered as ordered by the physician for 1 of 3 sample residents (#71) identified as requiring insulin for the management of diabetes. The findings were: Review of the medical record for resident #71 showed the resident was admitted to the facility on 6/7/06 with diagnoses including diabetes. Review of the MDS assessment dated 12/20/13 showed the resident was severely cognitively impaired and was a diabetic. Review of the care plan reviewed 9/24/13 showed the resident had an alteration in endocrine function related to diabetes. Interventions included administering Novolog regular insulin as ordered, and the goal was for the resident to have "no low BGs [blood glucose]." Review of the medical record showed a physician's recapitulation of orders, entitled, "Physician's Orders Discontinue All Previous Orders." These orders were signed and dated by the resident's current physician on 11/13/13 and 1/14/14 and included administering, "Regular insulin 3 units SQ [subcutaneous] if sugar >300 at 1700 [5 PM] and 3 units SQ if >300 at 2000 [8 PM]." The physician's order sheet also included a renewal date that was signed and dated by the	F 309	The facility will ensure necessary care and services are provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for resident #71 and all residents. B)Recertifications and orders for resident #71 and all residents will match the electronic medical record. C)Recertifications will be reviewed by the charge nurse before the physician visit is due and matched against the orders and the electronic medical record. Copies will be saved for future review. 24 hour chart check will be done every night to double check all new orders or recertifications to ensure consistency. D)Education will be provided to nursing staff on the importance of accurately reviewing the recertification and the 24 hour chart checks. E)Monitoring of compliance will be done by weekly random review of two recertifications against the MAR by supervisors using the quality improvement monitoring tool until substantial compliance has been met.	

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F 309	Continued From page 6 physician on 1/14/14 that included the following instructions; "pharmacy may fill prescriptions in context with the above orders, continue these orders for 60 days unless otherwise specified." The physician's order sheet was noted and signed by nursing staff on 1/15/14. The pharmacist review and signature dates remained unsigned on both the 11/13/13 and 1/14/14 physician order sheets. The following concerns were identified: a. Review of the electronic medication administration records (e-MARs) from October 2013 to February 2014 showed the resident had been receiving 3 units of regular insulin three times a day with meals if his/her blood glucose was greater than 300. The physician's signed recapitulation did not match the e-MAR. b. Review of the e-MARs dated 11/1/13 through 2/12/14 showed the resident was receiving Novolin R 3 units three times a day with meals if the residents blood sugar was greater than 300, which was "ordered on 10/22/2013." Interview with the pharmacist on 2/13/14 at 9 AM revealed medications were renewed monthly for a year, then required a physician's order to renew the prescription. The pharmacist explained the insulin was probably re-ordered by the physician on 10/22/13, however, no physician order was provided. Interview further revealed the pharmacy provided the facility with the e-MAR but the facility was responsible for reviewing the physician's recapitulation order sheets and the pharmacy did not receive a copy for review. c. Review of nursing notes dated 10/22/13 through 2/6/14 showed the resident had experienced 7 instances of low blood sugars that required medical interventions including administering glucose gel and/or orange juice with added packets of sugar.	F 309	F)Nurses not accurately reviewing the recertifications against the eMAR will receive immediate in-servicing and corrective actions will be taken. G)Results will be reported quarterly as part of the facility quality assurance program.	

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F 309	Continued From page 7 d. Interview with the DON on 2/11/14 at 4:05 PM revealed the process for reconciling e-MARs with current physician orders was done when nursing staff performed twenty four hour chart checks reviewing physician orders, and when the resident was due for recertification. Interview further revealed the facility did not have a specific process for reconciling e-MARs on a month to month basis with the physician's signed and dated order sheet. e. Interview with the physician on 2/12/14 at 11:45 AM verified he was the resident's physician and a complete list of medications was reviewed when progress notes were updated (or every 60 days) and as needed. The physician verified the resident was seen for his/her annual history and physical on 1/14/14 and medications were reviewed and signed by him at that visit, including the order for regular insulin 3 units if blood sugar greater than 300 at 5 and 8 PM. Interview further revealed the physician was unaware the resident had been receiving regular insulin 3 units three times a day with meals if his/her blood sugar was greater than 300 as listed on the e-MAR.	F 309		
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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and	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.	03/30/14

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F 312	Continued From page 8 procedure review, the facility failed to ensure staff provided nail care for 2 of 13 sample residents (#29, #70) and one non-sample resident (#21) who were dependent upon staff for ADLs. In addition, the facility failed to ensure facial hair grooming for 1 non-sample resident (#21) The findings were: 1. Review of the medical record showed resident #21 had diagnoses which included Alzheimer's dementia and depression. Review of the 1/13/14 quarterly MDS assessment showed the resident required total assistance with personal hygiene from staff. Periodic observations from 2/10/14 at 6:20 PM through 2/13/14 at 9:20 AM revealed the resident had dirty fingernails on both hands. In addition, the resident had untrimmed/unkempt facial hair. 2. Review of the medical record showed resident #29 had diagnoses which included Down Syndrome and depression. Review of the 12/6/13 quarterly MDS assessment showed the resident required total assistance with personal hygiene from staff. Period observations from 2/10/14 at 6:20 PM through 2/13/14 at 9:20 AM revealed the resident had dirty fingernails on both hands. 3. Review of the medical record showed resident #70 had diagnoses which included depression and ataxia (defective muscular coordination). Review of the 12/31/13 quarterly MDS assessment showed the resident required total assistance with personal hygiene from staff. Observation on 2/12/14 at 9:30 AM revealed the resident had long fingernails. The right middle fingernail was torn and had a sharp edge. Interview at that time with the resident revealed staff failed to cut the resident's nails unless s/he	F 312	A)The facility will ensure appropriate nail care and facial grooming are provided for residents #29 and #70 and for all residents. B)Education will be provided to all staff on the importance of providing appropriate nail care and facial grooming. C)Monitoring of compliance will be done by weekly random rounds observing nail care and facial grooming by supervisors of two residents using the quality improvement monitoring tool until substantial compliance has been met. D)Staff not providing appropriate nail care and facial grooming will receive immediate in-servicing and corrective action will be taken. E)Results will be reported quarterly as part of the facility quality assurance program.	

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F 312	Continued From page 9 asked. Interview with RN #2 on 12/12/14 at 9:45 AM confirmed nurses cut resident fingernails when CNAs informed the nurses when a resident required nail care. 4. Interview with activity aide #1 on 2/12/14 at 3:50 PM confirmed resident fingernails should be cleaned and trimmed on Mondays and bath days. Interview with the DON on 2/12/14 at 4:20 PM confirmed facility staff were required to keep fingernails of all residents, which included residents #21, #29, and #70, cleaned and trimmed, and facial hair shaved. 5. According to the facility policy and procedure titled "Nail Care" revised 5/8/13, "Nail care includes daily cleaning and regular trimming."	F 312		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	The facility will store all drugs and biologicals in locked compartments under proper temperature control and permit only authorized personnel to have access to the keys, in accordance with state and federal laws. A)The facility will ensure the first and second floor medication rooms and all drug and biological storage areas are locked when unsupervised. B)Education will be provided to all licensed nurses on the importance of keeping drugs and biologicals locked.	03/30/14

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F 431	Continued From page 10 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 1 of 2 medication rooms were secured during a random observation. The findings were: Observation on 2/12/14 at 2:40 PM revealed RN #1 exited the 2nd floor medication room and entered the employee break room around the corner from the medication room. The door did not completely close and was easily pushed open. During the observation a confused resident was observed at the nursing station desk near the open medication room. There were no staff present at the nursing station near the open medication room until 2:47 PM. Interview with RN #1 at the time of the observation revealed she was unaware the medication room was not locked and no staff were present at the nursing desk. Interview with the DON on 2/12/14 at 3:30 PM	F 431	C)Monitoring of compliance will be done by weekly random rounds checking two drug and biological storage areas using the quality improvement monitoring tool by supervisors until substantial compliance has been met. D)Nurses not locking medication rooms will receive immediate in-servicing and corrective action will be taken. E)Results will be reported quarterly as part of the facility quality assurance program.	

3/10/14

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

PRINTED: 02/28/2014
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 _____	02/13/2014

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

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F 431	Continued From page 11 verified medication rooms should remain locked when staff were not present.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission 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	F 441	The facility will ensure it establishes and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. A)The facility will ensure gloves are worn during insulin administration for resident #66 and all residents. B)Education will be provided to all licensed nurses on the importance of wearing gloves during insulin administration. C)Monitoring of compliance will be done by weekly random rounds observing insulin administration of two residents by supervisor using the quality monitoring tool until substantial compliance has been met.	03/30/14

3/18/14

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F 441	Continued From page 12 Infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure gloves were worn during insulin administration during 1 random observation for non-sample resident #66. The findings were: Observation of a medication pass on 2/12/14 at 5:17 PM revealed LPN #1 prepared and administered subcutaneous insulin to resident #66. LPN #1 injected the resident's insulin with bare hands. Interview with the LPN at the time of the observation revealed she was unaware she had to wear gloves when administering injectable insulin. Interview with the DON on 2/12/14 at 5:30 PM revealed she expected staff to wear gloves when administering injectable medication, including insulin. According to, "The Long Term Care Guide for Infection Control" copyright 2008, "Gloves serve an important purpose in infection control...and are worn to provide a barrier against pathogens and prevent contamination...gloves should be worn in all situations where you may come in contact with blood or body fluids (such as administering injectable medications). In addition, current standards of practice from the Centers for Disease Control and Prevention dated May 2011, "Standard Precautions are the minimum prevention practices that apply to all patient care...2. use of personal protective equipment	F 441	D)Nurses observed not wearing gloves during insulin administration will receive immediate in-servicing and corrective action will be taken. E)Results will be reported quarterly as part of the facility quality assurance program.	

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F 441	Continued From page 13 [gloves] should be worn when there is contact with blood and/or body fluids."	F 441		

4/18/14