5/22/15

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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 _____	04/09/2015

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 On 4/6/15-4/9/15 the Office of Healthcare Licensing and Surveys conducted a recertification survey at New Horizons Care Center. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing GI- Gastrointestinal IP- Infection Preventions LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 167 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 167	The facility will immediately inform the residents' physician and legal representative or interested family member of accidents which result in injury to the resident, significant changes in the resident's physical, mental, or psychosocial status, or decision to transfer or discharge a resident from the facility.	5/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rick Schwab — TITLE: CEO/LNHA — (X6) DATE: 5-14-15

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.

MAY 01 2015
Wyoming Department of Health
Healthcare Licensing and Surveys

Accepted on 5/26/15 w/ changes discussed with Joan (DON).

SR 5/26/15

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, and staff interview, the facility failed to ensure the physician was notified related to acute symptoms of illness for 7 of 7 sample residents (#11, #12, #13, #14, #15, #17, #18) with acute illness. The findings were: 1. Review of the infection control list provided by the facility showed resident #12 was identified with symptoms of a GI illness which included diarrhea on 4/4/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record for the resident failed to include any orders for the therapeutic diet or other documentation to show the physician was notified of the resident's symptoms. 2. Review of nurses' notes dated and timed 4/5/15 at 10:09 AM, and 4/5/15 at 6:52 PM showed resident #11 had at least 3 episodes of	F 157	A) The facility will ensure the physician is notified related to acute illness of resident #11, #12, #13, #14, #15, #17, #18, and all other residents. B) All nurses will be educated on the importance and procedures of immediately reporting changes in condition to the physician and legal representative/family member. C) Monitoring of compliance will be done by weekly random review of the "Physician's rounds list" by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not notifying the provider of acute illness 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 157	Continued From page 2 diarrhea and one episode of vomiting. Review of the medical record for the resident failed to include any documentation to show the physician was notified of the resident's symptoms. 3. Review of the infection control list provided by the facility showed resident #13 was identified with symptoms of a GI illness which included nausea, vomiting, and diarrhea beginning on 4/6/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record for the resident failed to include any orders for the therapeutic diet or other documentation to show the physician was notified of the resident's symptoms. 4. Review of facility infection tracking information showed resident #15 had GI illness symptoms of nausea and diarrhea which started on 4/7/15. Observations in the secure unit on 4/7/15 through 4/9/15 showed the resident was in his/her room in bed due to the continued GI illness. Interview with CNA's #1 and #2 on 4/7/15 at 10:15 AM confirmed the resident was in bed because "[the resident] has the GI illness and has had diarrhea and nausea." Review of the medical record showed no evidence the resident's physician was notified of the illness. 5. Review of facility infection tracking information showed resident #17 had GI illness symptoms which started on 4/5/15 with isolation ending on 4/9/15. Interview with CNA #1 on 4/7/15 at 10:45 AM confirmed the resident previously had a GI illness, but no longer had symptoms. Review of the medical record showed no evidence the resident's physician was notified of the illness.	F 157		

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F 157	Continued From page 3 6. Review of infection tracking information on 4/6/15 revealed resident #14 was having symptoms that included nausea, vomiting, and/or diarrhea. Review of the facility's 24-hour report revealed the resident was identified on 4/6/15 as having nausea and vomiting "x1". Interview with LPN #1 on 4/8/15 at 5:30 PM revealed the resident had vomiting the day before (4/7/15). Review of the resident's medical record showed no evidence the physician was notified of the resident's symptoms. Interview with the DON on 4/9/15 at 10:05 AM confirmed physicians should be notified and updated in a timely manner concerning residents with GI symptoms. 7. Review of the nursing 24 hour report showed resident #18 complained of a sore throat and head cold on 4/5/15, 4/6/15, and 4/7/15. The following concerns were identified: a. During an interview on 4/7/15 at 8:42 AM the resident stated s/he had a "bad cold." The resident stated s/he had symptoms for 4 days and had not seen a physician yet. The resident further stated the communication between facility staff and physicians was "not good." b. Review of the medical record on 4/7/15 showed no evidence the physician was notified of the resident's symptoms of an acute illness. Review of the facility's "physician wish list" (list of residents to be seen next time a physician was in the facility) showed the resident was added to the list on 4/6/15 for complaints of a sore throat and head congestion. c. Review of nursing notes on 4/8/15 showed the resident had increased coughing and was seen by the nurse practitioner on 4/8/15 (3 days	F 157		

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F 157	Continued From page 4 after symptoms were doucumented). An antibiotic was ordered for an upper respiratory infection. d. During an interview on 4/8/15 at 4:20 PM the medical director stated the "wish list" was for things that did not need to be addressed timely. He stated there was no criteria for when to use the "wish list" versus when to call the physician; it was left to nursing judgement. When given the example of resident #18's symptoms, the medical director stated the physician should have been notified "within a day or two."	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility 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:	F 280	The facility will ensure a comprehensive care plan is developed for residents #15 and #17 and all other residents within seven days after the completion of the comprehensive assessment prepared by the interdisciplinary team. A) The care plan for resident #15 and #17 will include the pressure ulcer and interventions. B) Care plans will be reviewed by the interdisciplinary team quarterly. Daily changes will be made and followed by the primary nurse and Certified Nursing Assistant and any other staff working with the resident. C) 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. D) 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. E) Staff not updating care plans will receive immediate in-service and corrective action will be taken. F) Results will be reported quarterly as part of the facility Quality Assurance Program.	5/24/15

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F 280	Continued From page 5 Based on observation, medical record review, and staff interview, the facility failed to update the care plan to include all required interventions for 2 of 13 sample residents (#15, #17). The findings were: 1. Observation with LPN #2 on 4/7/15 at 4:46 PM showed resident #16 had a stage II pressure ulcer to the left heel, and that a previous pressure ulcer to the right heel had healed. Review of the 2/5/15 significant change MDS assessment showed the resident was at risk for pressure ulcers. Review of the 3/26/15-4/1/15 Weekly Wound Report-Pressure Wounds, showed the resident had a stage II pressure ulcer to the right heel with interventions which included changing the resident's position every 2 hours and float heels. Review of the care plan showed the facility failed to include the pressure ulcer or interventions. 2. Observation with LPN #2 on 4/7/15 at 4:45 PM showed resident #17 had a stage II pressure ulcer to the right heel. Review of the 2/16/15 annual MDS assessment showed the resident was at risk for pressure ulcers. Review of the 3/26/15-4/1/15 Weekly Wound Report-Pressure Wounds, showed the resident had a stage II pressure ulcer to the right heel with interventions which included to float the resident's heels. Review of the care plan showed the facility failed to include the pressure ulcer or interventions. Interview with the MDS coordinator on 4/8/15 at 2:35 PM confirmed the care plans for residents #15 and #17 should include their pressure ulcers and interventions.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	The facility will ensure each resident receives and the facility provides the necessary care and services to	5/24/15

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F 309 SS=E	Continued From page 6 HIGHEST WELL BEING 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 observation, resident and staff interview, medical record review, and review of facility infection control documentation and 24-hour reports, the facility failed to ensure nursing assessments were completed to determine appropriate interventions for resident care. These assessments were lacking for 7 of 7 sample residents (#11, #12, #13, #14, #15, #17, #18) identified with acute symptoms of illness. The findings were: 1. Review of the infection control list provided by the facility showed resident #12 was identified with symptoms of a GI illness which included diarrhea on 4/4/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record for the resident failed to include any orders for the therapeutic diet or other documentation to show the physician was notified of the resident's symptoms. Additionally, there was no nursing assessment in the medical record related to the resident's signs and symptoms of the GI illness. 2. Review of nurses' notes dated 4/5/15 at 10:09	F 309	attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A) The facility will ensure residents #11, #12, #13, #14 #15, #17, and #18 when identified with acute symptoms of illness and all other residents with acute symptoms of illness receive nursing assessments to determine appropriate interventions. The facility will ensure these assessments are documented in the medical record. B) All nurses will be educated on the importance of completing and documenting nursing assessments for residents with acute symptoms of illness. C) Monitoring will be done by weekly random review of the provider rounds list and nursing documentation by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not completing and documenting nursing assessments on residents with acute symptoms of illness 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 309	Continued From page 7 AM, and 4/5/15 at 6:52 PM showed resident #11 had at least 3 episodes of diarrhea and one episode of vomiting. Review of the medical record for the resident failed to include any documentation to show the physician was notified of the resident's symptoms. Further review of infection control information showed as of 4/6/15 the resident continued to have GI symptoms; however, a nursing assessment was lacking concerning the resident's symptoms of the illness. 3. Review of the infection control list provided by the facility showed resident #13 was identified with symptoms of a GI illness which included nausea, vomiting, and diarrhea beginning on 4/6/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record for the resident failed to include any orders for the therapeutic diet or other documentation to show the physician was notified of the resident's symptoms, or that a nursing assessment was completed related to the GI illness. 4. Review of facility infection tracking information showed resident #16 had GI illness symptoms of nausea and diarrhea which started on 4/7/15. Observations in the secure unit on 4/7/15 through 4/9/15 showed the resident was in his/her room in bed due to the continued GI illness. Interview with CNA's #1 and #2 on 4/7/15 at 10:15 AM confirmed the resident was in bed because "[the resident] has the GI illness and has had diarrhea and nausea." Review of the medical record showed no evidence the resident's physician was notified of the illness or that a nursing assessment was done.	F 309		

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F 309	Continued From page 8 6. Review of facility infection tracking information showed resident #17 had GI illness symptoms which started on 4/6/15 with isolation ending on 4/9/15. Interview with CNA #1 on 4/7/15 at 10:46 AM confirmed the resident previously had a GI illness, but no longer had symptoms. Review of the medical record showed no evidence the resident's physician was notified of the illness and there lacked evidence of a nursing assessment. 6. Review of infection tracking information on 4/6/15 revealed resident #14 was having symptoms that included nausea, vomiting, and/or diarrhea. Review of the facility's 24-hour report revealed the resident was identified on 4/6/15 as having nausea and vomiting "x1". Interview with LPN #1 on 4/8/15 at 5:30 PM revealed the resident had vomiting the day before (4/7/15). Review of the medical record showed no evidence a nursing assessment was completed. Interview with the DON on 4/9/15 at 10:05 AM confirmed physicians should be notified and updated in a timely manner concerning residents with GI symptoms. She further confirmed there lacked evidence of a nursing assessment for the residents with GI symptoms. 7. Review of the nursing 24-hour report showed resident #18 complained of a sore throat and head cold on 4/5/15, 4/6/15, and 4/7/15. During an interview on 4/7/15 at 8:42 AM the resident stated s/he had a "bad cold." The resident stated s/he had symptoms for 4 days and had not seen a physician yet. The following concerns were identified: a. Review of the medical record showed no evidence a nursing assessment was completed. b. Review of the medical record on 4/7/15	F 309		

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F 309	Continued From page 9 showed no evidence the physician was notified of the resident's symptoms of an acute illness. Review of the facility's "physician wish list" (list of residents to be seen next time a physician was in the facility) showed the resident was added to the list on 4/5/15 for complaints of a sore throat and head congestion. Review of nursing notes on 4/8/15 showed the resident had increased coughing and was seen by the nurse practitioner on 4/8/15 (3 days after symptoms were documented). An antibiotic was ordered for an upper respiratory infection. During an interview on 4/8/15 at 4:20 PM the medical director stated the physician should have been notified "within a day or two" for the symptoms the resident had.	F 309		
F 332 SS=D	483.25(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 a medication error rate under 5 percent (%). Two medication errors were observed out of 25 opportunities for error, which resulted in an error rate of 8%. The findings were: 1. Observation on 4/7/15 at 8:05 AM showed LPN #3 prepared medication for resident #34. The LPN crushed all of the medications at that time, which included one potassium chloride extended release 10 mg capsule. She opened the capsule and poured the contents into the container with	F 332	The facility will ensure it is free of medication error rates of five percent or greater. A) Residents #34 and #13 and all other residents will not receive crushed medications that should not be crushed. B) Education will be provided to all nursing staff on the importance of not crushing medication that should not be. C) Monitoring of compliance will be done by weekly random rounds observing medication preparation and administration for two residents. D) Nurses not providing appropriate medication 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.	5/24/15

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F 332	Continued From page 10 the resident's additional medications and crushed them all. She then administered the medications to the resident in pudding. Medical record review showed the medication was ordered by a physician. Interview with the LPN on 4/7/15 at 8:30 AM confirmed she should not have crushed the potassium chloride extended release. 2. Observation on 4/8/15 at 5:40 PM showed LPN #4 prepared medication for resident #13. The LPN crushed all of the medications at that time, which included one metoprolol extended release 50 mg. She then administered the medications to the resident in pudding. Medical record review showed the medication was ordered by a physician. Interview with the LPN on 4/8/15 at 5:55 PM confirmed she should not have crushed the metoprolol extended release. According to the "Institute for Safe Medication Practices" last updated 10/1/11, "Oral Dosage Forms That Should Not Be Crushed", the list included potassium chloride extended release and metoprolol extended release.	F 332		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of dietary information, and staff interview, the facility failed to ensure therapeutic diets were ordered by a physician for 2 of 2 sample residents (#12, #13) who had a change in	F 367	The facility will ensure therapeutic diets are prescribed by the attending physician. A) The facility will ensure residents #12 and #13 and all other residents have correct physician's orders for their current diets. B) Education will be provided to all nursing staff on the importance of obtaining physician's orders for the resident diets. C) Monitoring of compliance will be done by weekly random review of two resident diets and the physician's orders until substantial compliance has been met. D) Nurses not obtaining a physician diet order will receive immediate in-servicing and corrective action will be taken.	5/24/15

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	536030	A. BUILDING _____ B. WING _____	04/09/2015

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F 367	Continued From page 11 therapeutic diets. The findings were: Observation on 4/7/15 at 8:10 AM showed resident #12 and #13 were served clear liquid diets. Observation on 4/8/15 at 3:45 PM in the kitchen showed a list of residents who were to be served clear liquid diets "until further notice." On that list were 10 names, which included residents #12 and #13. Interview with RN #1 on 4/8/15 at 11:10 AM verified these therapeutic diets were provided as a result of GI illness symptoms. The nurse stated the protocol used by nursing was to change the diet as needed and then to have the physician order the diet within 3 days. Interview with the nurse further revealed resident #12 began the clear liquid diet on 4/4/15. Observation showed the resident remained on the clear liquid diet until 4/8/15 at 5:50 PM. Review of the medical record showed there was no evidence a physician was notified of the resident's symptoms of acute illness or that a physician was aware the resident was receiving a clear liquid diet. In addition, there was no nursing or dietary assessment done related to the residents change in dietary intake. Interview with the registered dietitian on 4/9/15 at 9 AM verified she was not aware of the length of time the residents were continued on a clear liquid diet. Interview with the medical director on 4/8/15 at 4:20 PM revealed a physician needed to order the clear liquid diets being used to treat the residents, and he wouldn't want to see a clear liquid diet last longer than 2 days.	F 367	E) Results will be reported quarterly as part of the facility Quality Assurance Program.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	The facility will ensure it procures food from sources approved or considered satisfactory by Federal, State or local authorities and serve food under sanitary conditions. A) The facility will ensure the "Vulcan" oven doors and all walls and ceiling vents throughout the kitchen are	5/24/15

5/26/15

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F 371	Continued From page 12 considered satisfactory by Federal, State or local authorities; and (2) 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 ensure a sanitary environment in the kitchen. The findings were: 1. Observation on 4/8/15 at 5:20 PM in the kitchen showed the following items which were in need of more frequent cleaning: a. The outside of the "Vulcan" oven doors were soiled with dried on food and grime. Interview with cook #1 at that time verified the ovens were not used; however, the range top directly above the ovens were used daily. b. The wall behind a food preparation counter was soiled with splattered dried food/liquids. c. The four large ceiling vents throughout the kitchen had accumulations of dark colored dust and grease on and surrounding them. In addition, the wall near the three compartment sink was unclean with stuck on dust/grease. d. Interview with the dietary manager on 4/8/15 at 10:55 AM confirmed the unclean condition of these areas/items and verified they were in need of more frequent cleaning. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other	F 371	kept free of an accumulation of dust, dirt, food residue, and other debris. B) The facility will ensure staff keep personal food and drink in an area away from the food production and service areas. C) The facility will ensure rodent bait is contained in a covered, tamper-resistant bait station. D) The facility will ensure materials that are used in the construction of utensils and food contact surfaces of equipment do not allow the migration of deleterious substances or impart colors, odors or tastes to food and under normal use conditions are safe, durable, corrosion-resistant, and nonabsorbent. They will be sufficient in weight and thickness, finished to have a smooth, easily cleanable surface, and resistant to pitting, dripping, crazing, scratching, scoring, distortion, and decomposition. E) Education will be provided to all staff on the importance of serving food under sanitary conditions. F) Monitoring of compliance will be done by weekly random observation of the kitchen using the quality improvement monitoring tool until substantial compliance has been met. G) Staff observed not serving food under sanitary conditions will receive immediate in-servicing and corrective action will be taken. H) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 371	Continued From page 13 debris." 2. Observation of the kitchen on 4/6/15 at 5:20, showed cook #1 was eating and drinking behind the service line counter. When the cook started serving the resident meal, the remaining food and drink she was eating remained uncovered on the end of the service line counter. Interview with the dietary manager on 4/8/15 at 10:55 AM verified staff were expected to keep personal food and drink in an area away from the food production and service areas. According to Food Code 2013, U.S. Public Health Service, 2-401.11: "(A) Except as specified in ¶ (B) of this section, an EMPLOYEE shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection can not result." 3. Observation in the dry food storage room on 4/6/15 at 5:25 PM and on 4/8/15 at 10:55 AM showed a uncovered rodent glue trap located under a shelving unit. Interview with the dietary manager on 4/8/15 at 10:55 AM stated she was unaware rodent traps needed to be enclosed in food storage areas. According to Food Code 2013, U.S. Public Health Service, 7-206.12: "Rodent bait shall be contained in a covered, tamper-resistant bait station." 4. Observation on 4/6/15 at 5:20 PM and on 4/8/15 at 10:55 AM showed 7 plastic food storage containers which were located on a clean dish	F 371		

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F 371	Continued From page 14 rack. These containers were noted to be in poor condition with cracks and fissures in the plastic not allowing for effective cleaning/sanitation. Interview with the dietary manager on 4/8/15 at 10:55 AM verified these items needed to be replaced. According to Food Code 2013, U.S. Public Health Service: 4-101.11 "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition."	F 371		
F 441 SS=H	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;	F 441	The facility will ensure it establishes and maintains 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) The facility will ensure it effectively implements measures to prevent the development and transmission of infection for residents #3, #11, #12, #13, #14, #15, #17, #25, #26, #28, #34, #36, #39, #40, #54, #59, and #60 and all other residents. & Resident's # 61, 62, 65 B) The facility will implement an illness outbreak tracking tool for residents and staff. C) The facility will create an illness outbreak guidance tool for staff to follow in the event of an outbreak.	5/24/15

Per phone conversation w/ Tracy on 5/21/15 @ 8:27am

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F 441	Continued From page 16 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of infection control documentation, the facility failed to effectively implement measures to prevent the spread of a known GI illness occurring within the facility. The initial number of residents affected with GI illness was 12, five of 13 sample residents (#11, #12, #13, #14, #17) and 7 non-sample residents (#3, #28, #34, #39, #40, #54, #60). Failure to implement precautions timely and effectively resulted in harm to 8 additional residents (#15, #25, #26, #36, #59,	F 441	D) Education will be provided to all nursing staff on the importance of effectively implementing measures to prevent the development and transmission of infection E) Monitoring of compliance will be done bi-weekly review of physician's orders, physician's rounds list, and 24 hour report by the Infection Control nurse using the quality improvement monitoring tool until substantial compliance has been met. F) Nurses not effectively implementing measures to prevent the development and transmission of infection will receive immediate in-servicing and corrective action will be taken. G) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 441	Continued From page 16 #61, #62, #65) who became infected with the illness as of 4/8/15. The census was 71. The findings were: Upon entrance to the facility on 4/6/15 at 4:35 PM, the DON stated that some residents and staff were experiencing GI symptoms. Review of the infection tracking information on 4/6/15 showed there were 11 residents (#3, #11, #12, #13, #14, #17, #28, #34, #39, #54, #60) who had symptoms including nausea, vomiting and diarrhea. The onset date of the symptoms showed the first residents affected were identified on 4/4/15. Observation during a tour of the facility on 4/6/15 from 4:55 PM to 6:30 PM revealed there was no personal protective equipment (PPE) or signage outside of any resident rooms. Interview with the IP on 4/6/15 at 6:45 PM verified the residents experiencing symptoms were located in the two upper level units of the facility (the secure unit, and the 7/8 unit). The IP then verified other than keeping the upper and lower level residents separated, there were no isolation precautions in place. In addition, she stated at that time formal education had not been provided to staff, just verbal reminders regarding good hand hygiene practices. Furthermore, the IP stated there were some employees with symptoms of the illness and the facility did not have specific requirements for when they could return to work. She revealed at that time the outbreak had not yet been reported to any State officials. The following concerns were identified: a. Observations on 4/7/15 at 8 AM showed residents in the 7/8 unit were located in the dining area being served breakfast. At 8:12 AM resident #13 had an episode of emesis while seated at the table. CNA #3 who was assisting the resident used the clothing protector to absorb the small	F 441		

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F 441	Continued From page 17 amount of emesis and failed to remove the soiled clothing protector from the resident or to perform hand hygiene prior to continuing to assist the resident. b. Observation on 4/7/15 at 8:15 AM showed resident #40 was taken away from the table where he was dining with other residents. The resident was placed at an adjacent table alone with a vomit basin because s/he was feeling nauseous. c. Interview on 4/7/15 at 8:15 AM with LPN #5 the 7/8 unit nurse verified there were more residents getting ill, and none of the residents were on isolation. She then stated she had not been educated on any procedures related to the outbreak. d. Observation on 4/7/15 at 7:45 AM showed resident #17 had door signage which stated, "Please speak with a nurse before visiting your loved one." At that time the resident was at the main secure unit dining area eating breakfast. The observation showed there were three additional residents at the same dining table. e. Observation on 4/7/15 at 8 AM showed LPN #3 performed a medication pass in the secure unit. The LPN was observed to wear one pair of gloves while administering medications to a number of residents. At no time was she observed to change gloves or wash hands. Interview with LPN #3 on 4/7/15 at 8:30 AM confirmed she should have changed gloves and washed hands as appropriate during the medication pass. f. Observation on 4/7/15 beginning at 7:45 AM showed resident #25 sitting at the dining table in the common room vomiting into his/her clothing protector. At that time, CNAs #2 and #4 responded by wheeling the resident back to his/her room. Both CNAs then donned gloves.	F 441		

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F 441	Continued From page 18 The resident vomited again into the clothing protector and onto the floor before stating that s/he felt better. CNA #2 wiped the resident's face with a washcloth, removed her gloves, and did not perform hand hygiene before providing the resident a cup of water. CNA #4 bagged the soiled washcloth and clothing protector. She then removed her gloves, donned new gloves, and used paper towels to wipe up vomit off the floor. No hand hygiene was performed between gloving. She placed the soiled paper towels in the resident's trash can. She then removed her gloves, did not perform hand hygiene, donned new gloves, and selected a clean shirt from the resident's closet. Both CNAs then assisted the resident with changing clothes and getting into bed. Both CNAs then used hand sanitizing gel after leaving the resident's room. g. Interview with housekeeper #1 on 4/7/15 at 10:15 AM verified she had not been provided any instruction to modify her cleaning process. The housekeeper stated the hand rails in each area were wiped with a disinfectant product once per week. h. Review of the list provided showed 7 employees (5 CNAs and 2 licensed nurses) were out ill with GI symptoms as of 4/9/15. Interview with the IP on 4/9/15 at 11:30 AM verified the employees needed to be free from symptoms for 72 hours before they would be allowed back to work. i. Interview with the medical director on 4/8/15 at 4:20 PM revealed he was not aware of the scope of the outbreak. The medical director learned during the interview there were 19 residents affected. Further the medical director verified his expectation would be for the residents' physicians to be notified about those experiencing acute illness within the day of onset of symptoms.	F 441		

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F 441	Continued From page 19 In addition, the physician verified the residents needed to be assessed for their symptoms and details needed to be documented related to the condition of the residents. He further stated his expectation was for a daily update related to the status of those affected in the facility. j. When the updated resident infection control information was reviewed on 4/8/15 at 3:55 PM there were 8 additional residents (#15, #25, #26, #36, #59, #61, #62, #65) who were now identified with symptoms of the GI illness since the initial 4/6/15 information.	F 441		
F 501 SS=E	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on review of facility infection control documentation and medical director interview, the facility failed to ensure the medical director received accurate and timely information concerning an outbreak of GI symptoms in the facility. The findings were: Upon entrance to the facility on 4/6/15 at 4:35 PM, the DON stated that some residents and staff were experiencing GI symptoms. Review of the infection tracking information on 4/6/15 showed there were 11 residents (#3, #11, #12, #13, #14, #17, #28, #34, #39, #54, #60) who had	F 501	The facility will ensure the medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. A) The facility will ensure the medical director receives immediate and daily updates during outbreaks. B) All nurses will be educated on the importance of notifying the medical director of an outbreak immediately and updating on a daily basis. C) Monitoring of compliance will be done by bi-weekly random review of the physician's orders, physician's round list and 24 hour report sheets by the Infection Control nurse using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not notifying the medical director of outbreaks and updating on a daily basis 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.	5/24/15

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F 501	Continued From page 20 symptoms including nausea, vomiting and diarrhea. The onset date of the symptoms showed the first residents affected were identified on 4/4/15. Review of the updated infection tracking information on 4/8/15 at 3:55 PM showed an additional 8 residents (#15, #25, #26, #36, #59, #61, #62, #65) were identified with symptoms of the GI illness. During an interview on 4/8/15 at 4:20 PM the medical director stated he was notified of the GI illness outbreak on Tuesday (4/7/15). The medical director was not aware the outbreak affected 19 residents; he stated "I thought it was only 3 or 4." The medical director further stated his expectation was that he should receive daily updates during an outbreak.	F 501		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview	F 514	The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. A) The facility will ensure it maintains complete and accurate medical records for residents #11, #12, #13, #14, #15, #17, and #18 and all residents. B) All nurses will be educated on the importance of maintaining complete and accurate medical records for all residents. C) Monitoring of compliance will be done by weekly random review of the 24 hour report against nurse charting on two residents using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not maintaining complete and accurate medical records 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.	5/24/15

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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 _____	04/09/2015

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 514	Continued From page 21 and review of infection control documentation and 24-hour reports, the facility failed to ensure the medical record was complete and accurate for 7 of 7 sample residents (#11, #12, #13, #14, #15, #17, #18) identified with acute symptoms of illness. The findings were: 1. Review of the infection control list provided by the facility showed resident #12 was identified with symptoms of a GI illness which included diarrhea on 4/4/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record showed there was no nursing assessment in the medical record related to the resident's signs and symptoms of the GI illness. 2. Review of nurses' notes on 4/6/15 at 10:09 AM, and 4/6/15 at 6:52 PM showed resident #11 had at least 3 episodes of diarrhea and one episode of vomiting. Review of the medical record showed no documentation of a nursing assessment concerning the resident's symptoms of the illness. 3. Review of the infection control list provided by the facility showed resident #13 was identified with symptoms of a GI illness which included nausea, vomiting, and diarrhea beginning on 4/6/15. Observation on 4/7/15 at 8:10 AM showed the resident was served a clear liquid diet which was done as a response to symptoms of the GI illness. Review of the medical record failed to show documentation of a nursing assessment related to the GI illness. 4. Review of facility infection tracking information showed resident #15 had GI illness symptoms of nausea and diarrhea which started on 4/7/15.	F 514		

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F 514	Continued From page 22 Observations in the secure unit on 4/7/15 through 4/9/15 showed the resident was in his/her room in bed due to the continued GI illness. Interview with CNA's #1 and #2 on 4/7/15 at 10:15 AM confirmed the resident was in bed because "[the resident] has the GI illness and has had diarrhea and nausea." Review of the medical record showed the facility failed to document the illness. 5. Review of facility infection tracking information showed resident #17 had GI illness symptoms which started on 4/6/15 with isolation ending on 4/9/15. Interview with CNA #1 on 4/7/15 at 10:45 AM confirmed the resident previously had a GI illness, but no longer had symptoms. Review of the medical record showed the facility failed to document the illness until 4/7/15. Review of a nursing note dated 4/7/15 at 3:27 PM stated, "No reports of loose stools; states [the resident] feels better." The facility failed to document the onset of the illness and an assessment of the resident during the illness. 6. Review of infection tracking information on 4/6/15 revealed resident #14 was having symptoms that included nausea, vomiting, and/or diarrhea. Review of the facility's 24 hour report revealed the resident was identified on 4/6/15 as having nausea and vomiting. Interview with LPN #1 on 4/8/15 at 5:30 PM revealed the resident had vomiting the day before (4/7/15). Review of the resident's medical record, including nursing notes and communication with physician, showed no documentation related to the illness. Interview with the DON on 4/9/15 at 10:05 AM confirmed residents with signs and symptoms of GI illness should be assessed, and the assessment with timely updates should be	F 514		

5/20/15

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F 514	Continued From page 23 documented in the medical record. 7. Review of the nursing 24-hour report (not part of the medical record) showed resident #18 complained of a sore throat and head cold on 4/5/15, 4/6/15, and 4/7/15. During an interview on 4/7/15 at 8:42 AM the resident stated s/he had a "bad cold." The resident stated s/he had symptoms for 4 days. Review of the medical record on 4/7/15 showed no documentation related to the resident's symptoms of acute illness.	F 514		