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

PRINTED: 10/19/2009
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 _____	C 10/08/2009

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 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post a notice of the availability of health survey results of the facility. The findings were: Observation on 10/05/09 at 4:48 PM revealed an unmarked plastic bin attached to the wall near the facility entrance. Inside the bin was a notebook labeled "Notice of Privacy Practices 4/14/03". Behind the notebook was a stapled copy of the previous year's survey results. Confidential interview with four of six residents on 10/06/09 at 1 PM revealed they were unaware of the existence of the previous year's survey results. They also stated they would be interested in reviewing them. Interview with the facility activities director on 10/8/09 at 8:15 AM revealed she was unaware of the availability and location of the previous year's survey results and also stated she had asked several other CNA's and "none of them knew of the availability or location of the previous year's results".	F 167	The facility will ensure the State survey results and plan of correction are posted in a readily available location with a notice indicating their availability to residents, employees, and the public. Education to residents regarding State survey results will be provided. Education to staff regarding State survey results will provided. Presence of the notice of availability of survey results will be monitored weekly by the Director of Nursing and reported Quarterly at Quality Assurance Meetings.	11/22/09
F 278	483.20(g) - (j) RESIDENT ASSESSMENT	F 278		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Bair — TITLE: Administrator — (X6) DATE: 11-6-2009

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.

approved = corrective on 11/06/09 @ 930 am via telephone

11/6/09 { call = adm. P. Aines, RN

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F 278 SS=D	Continued From page 1 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure the admission Minimum Data Set (MDS) assessment contained correct diagnostic information for 1 (#3) of 15 sample residents. The findings were: Medical record review for resident #3 revealed	F 278	The facility will conduct and coordinate each resident assessment with the appropriate participation of health professionals. A) The facility will ensure medical records contain appropriate medical diagnoses. B) The medical record of resident#3 will contain a diagnosis of Parkinson's Disease, as appropriate. C) Chart monitoring of two charts per week will be done by the MDS Coordinator and reported weekly at Utilization Review Meetings and quarterly to the Quality Assurance Committee.	11/22/09 11/22/09 11/22/09 11/22/09

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F 278	Continued From page 2 the admission MDS dated 9/4/08 showed the resident diagnosed with Parkinson's disease (section I, Disease Diagnoses). Review of the resident's care plan in multiple categories, e.g., urge incontinence, altered thought, hearing impairment, impaired physical mobility, etc. also revealed the diagnosis of Parkinson's disease as a contributing factor. Review of the entire medical record however did not reveal a diagnosis of Parkinson's disease. Interview with the Director of Nursing on 10/7/09 at 4 PM confirmed the resident did not have Parkinson's disease.	F 278		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to implement appropriate pressure sore prevention measures for 1 (#29) of 9 sample residents who were at risk for developing pressure sores. As a result of this failure, the resident developed an avoidable painful pressure sore. The findings were: Review of the 9/7/09 admission Minimum Data Set assessment for resident #29 showed the resident was admitted to the facility on 9/3/09 without pressure sores. Review of the pressure	F 314	The facility will ensure a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates the pressure sores were unavoidable. The facility will ensure a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. A) Pressure sores prevention measures will be implemented for resident #29 including protective devices for the resident's ankles. Physical Therapy evaluation consult will be completed for resident #29. Wound care nurse will provide education and competency training annually to all Certified Nursing Assistants about monitoring for and using care alerts to report skin changes in residents. Wound care nurse will review 24 hour report sheets three times per week and as needed to monitor for changes in skin condition. Skin changes will be reported in weekly Utilization Review Meetings. Skin assessments will be performed by nursing within 24 hours of admit and as needed.	11/22/09 11/22/09 11/22/09 11/22/09

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F 314	Continued From page 3 sore risk assessment, completed on the same day, revealed the resident's risk for developing pressure sores was high due to occasional urinary and bowel incontinence, impaired cognition, diabetes and chronic obstructive lung disease. Review of the nursing notes, dated 10/2/09, showed staff noted an "inflamed" area on the resident's left outer ankle and reported it to the physician. Review of the weekly skin measurement tool revealed the resident had one pressure sore that was painful and measured 1.2 centimeters (cm) x 1.3 cm on 10/5/09. Further review showed the resident had an additional stage II pressure sore on the same ankle on 10/8/09 . The documentation showed one pressure sore measured .5 x .5 cm and the second one, located directly above the first one, measured 2 x 2.5 cm and had serous drainage. Observation on 10/8//09 at 9:20 AM confirmed the appearance of the two pressure sores as documented on the 10/8/09 weekly skin measurement tool. The following concerns were identified: a. During interviews on 10/5/09 at 6:30 PM with registered nurse (RN) #1, on 10/7/09 at 7:05 AM with certified nurse aide (CNA) #1 and on 10/7/09 at 7:15 AM with RN #2, all three said pressure was exerted on the resident's ankles when s/he frequently crossed his/her legs. During the interview with RN #2, she also said staff applied a padded dressing over the pressure sore, but no additional protective or support cushion had been provided for the resident. She said staff was waiting for directions from the wound care nurse before they did anything more than follow the physician's orders for dressing changes. b. Review of the 9/7/09 care plan revealed	F 314	Chart reviews of admission skin assessments will be done and reported by the Wound Care Nurse at Utilization Review Meetings weekly and reported quarterly as part of the facility Quality Assurance Meeting. MB	11/22/09

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F 314	Continued From page 4 approaches to address the potential for impaired skin integrity, but the approaches did not include providing protective devices for the resident's ankles. c. Observation on 10/6/09 at 8:20 PM, 10/7/09 at 7:05 AM and again on 10/8/09 at 9:20 AM showed the resident in bed without support cushions, heel protectors or positioning for reducing the pressure on his/her ankles. Further observation of staff as they assisted the resident with morning care on 10/7/09 at 7:05 AM and again on 10/9/09 at 9:20 AM revealed the resident told staff that the pressure sore "hurts". d. Interview on 10/7/09 at 3:20 PM with the wound care nurse and on 10/8/09 at 1 PM with the DON revealed the facility's system for recognizing skin breakdown was dependent on the CNAs' ability to recognize and report it to the nurses. Both said the nurses did not routinely perform skin assessments on all of the residents and the facility did not do competency testing or training to ensure all CNAs were knowledgeable about reporting pressure sores. During the interview with the wound care nurse, she further stated she had not had the opportunity to complete the assessment to determine specific preventive skin care measures that needed to be implemented for the resident.	F 314		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441	The facility will follow appropriate infection control practices by handling and transporting soiled linen and clothing according to facility policy. A) The education coordinator will provide education to the nursing staff on transporting soiled linen using appropriate Infection Control procedures. B) Monitoring of compliance of staff will be done weekly by the charge	11/22/09 11/22/09

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F 441	Continued From page 5 the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: The facility failed to follow appropriate infection control practices during two of four observations of staff handling and transporting soiled linen and clothing. The findings were: 1. Observation on 10/6/09 at 7:40 PM of certified nurse aide (CNA) #2 showed the CNA assisted resident #59 with toileting, perineal cleansing and changing his/her clothing. Further observation showed the CNA did not wear gloves when she gathered the soiled linen and the soiled clothing removed from the resident. The CNA then clutched the items against her uniform, carried them out of the resident's room and across the atrium to the soiled linen room. 2. Observation on 10/6/09 at 8:00 PM of CNA #2 showed the CNA assisted resident #29 with toileting, perineal cleansing and changing his/her clothing. Further observation showed the CNA did not wear gloves when she gathered the soiled linen and soiled clothing removed from the resident. The CNA then clutched the items against her uniform and carried them out of the resident's room across the atrium to the soiled linen room. Interview with the CNA, at that time, revealed the CNA was aware of the linen transport procedures that prevent contamination, but the surveyor's presence made her "nervous". 3. According to the facility's policies and	F 441	nurse to include observation of one staff member on each shift transporting soiled linens. Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 441	Continued From page 6 procedures, staff was required to bag soiled linen items in laundry bags at the collection site, transport and place them in covered soiled linen hampers and covered bins within the soiled rooms. Interview on 10/8/09 at 1 PM with the Director of Nursing showed the CNA did follow the policy and procedures. 4. Review of the second edition of Hartman's Nursing Assistant Care, Long-Term Care showed the guidelines for handling, transporting and processing soiled linen and clothing required doing it "in a way that prevents contamination of clothing." Further review showed requirements for staff to "bag soiled linen at the point of origin" and "hold and carry dirty linen away from" their uniforms.	F 441		
F 465 SS=E	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the refrigerator/ freezer was maintained in a properly operating manner. The findings were: Observations on 10/5/09 at 4:30 PM and then again on 10/7/09 at 9:45 AM revealed a long tube (approximately 4 feet long and approximately 2 inches in diameter) of ice on the floor of the facility refrigerator. The ice was at the corner of the floor and the wall. The wall was the common wall shared with the facility freezer. Interview with the kitchen manager on 10/7/09 at 4:48 PM	F 465	The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public by ensuring the refrigerator/ freezer is maintained in a properly operating manner. A) The dietary freezer will be defrosted and ice removed from the floor. B) All freezers in the Dietary Department will be placed on a defrosting schedule and defrosted annually. C) Monitoring of freezer and ice build-up with a schedule and checklist will be compited by the Dietary Manager weekly and results reported at quarterly Quality Assurance Meeting.	11/22/09 11/22/09 11/22/09 11/22/09

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F 465	Continued From page 7 confirmed the presence of the ice on the floor. The manager also stated she did not know the cause of the ice formation.	F 465		