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

RECEIVED
MAY 15 2017
Healthcare Licensing and Surveys

PRINTED: 05/10/2017
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 04/26/2017

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 A complaint survey was conducted by Healthcare Licensing and Surveys on 4/24/17 through 4/26/17. The survey was prompted by complaint intake WY00002394. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	resident #1 has been discharged from the facility.	
F 157 SS=E	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (I) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157	A) The facility will ensure the physician and resident's family members are notified immediately of an accident involving any residents which results in injury and have the potential for requiring physician intervention. B) All nurses will be educated on the importance and procedures of immediately notifying the physician and resident's family member of an accident which results in injury and have the potential for requiring physician intervention. C) Monitoring of compliance will be done by weekly random review of two Fall Forms by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not notifying the physician and resident's family member 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.	05-20-2017 weekly x4 for residents #2 and #3

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erik Schrock — TITLE: LNHA — (X6) DATE: 5-12-17

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. Changes made per Traci Hudson, CNO, on 5/17/17 @ 10:50 am

with Janice Co via phone conf. POC accepted.
Janice Co

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on review of fall investigation documentation, staff interview, and review of facility policy, the facility failed to ensure the physician and resident's family member were notified immediately of an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 3 of 4 sample residents (#1, #2, #3) who had falls. The findings were: 1. Review of fall investigation documentation for	F 157		

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F 157	Continued From page 2 resident #1 showed s/he had a fall on 4/12/17 at 7:05 AM. The resident complained of knee paln and was "not bearing weight well." The physician was not notified until 10:30 AM (the resident was seen by the physician at that time during rounds) and the family was not notified until 10:05 AM. **2. Review** of fall Investigation documentation for resident #3 revealed the following concerns: a. The resident had a fall on 2/5/17 at 5 AM which resulted in a large hematoma to the left of the head. The physician's assistant (PA) was notified at 5:15 AM, but the family was not notified until 9:32 AM. b. The resident had a fall on 2/13/17 at 1:30 AM which resulted in a bump to the forehead, in addition to bruising on the knee and forearm. The documentation showed the physician was notified on 2/13/17, but did not indicate the time. The family was not notified until 10:25 AM. 3. Review of fall investigation documentation for resident #2 showed s/he had a fall on 3/20/17 at 3 AM which resulted in an abrasion to the forehead above the eye with contusion and swelling. The nurse practitioner (NP) was not notified until 10 AM, and the family was not notified until 10:05 AM. 4. During an interview on 4/26/17 at 11:37 AM the DON stated nursing staff should call the physician right away. She st ted that the timing of family notification depended on the resident, because some family members did not want to be called in the middle of the night. During a later interview on 4/26/17 at 12:14 PM the DON stated that there were no requests to not call in the middle of the night for residents #1, #2, or #3, therefore the family should have been called sooner.	F 157		

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F 157	Continued From page 3 5. Review of the facility's policy "Resident Falls" (10/5/16) revealed "During the day shift (until 9 PM) when a resident falls, the resident is to be checked for any apparent injuries by the nurse. The family and physician need to be notified of the fall. During the night, if a resident falls and had no apparent injury, then the nurse is to the notify the day nurse in the morning and the day nurse will be responsible to notify the physician and family. If during the night the resident falls and there is apparent injury requiring medical attention, the nurse in charge will notify the physician and family member immediately." During an interview on 4/26/17 at 12:14 PM the DON acknowledged the language in their policy differed from the language of the regulation; an injury requiring medical attention versus an injury with the potential to require physician intervention. She also acknowledged that when a resident hit their head during a fall, there was the potential for physician intervention.	F 157		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative services for ambulation were consistently implemented for 1 of 1 sample residents (#1) with a restorative plan. The findings were:	F 311	A) The facility will ensure all residents are given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. B) Resident #1 has been discharged from the facility. C) Restorative staff will be educated on the importance of ensuring all restorative plans are followed and documented. D) Monitoring of compliance will be done by weekly random review of two residents' restorative charting by the Restorative Nurse using the quality improvement monitoring tool until substantial compliance has been met.	05-20-2017

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F 311	Continued From page 4 Review of the care plan dated 3/29/17 for resident #1 showed an intervention for fall prevention was "Strengthening thru restorative." Review of the restorative therapy referral dated 3/24/17 showed the resident had a restorative plan "to maintain mobility and walking." The plan was for ambulation 3-5 times per week with a front-wheeled walker (FWW) and gaitbelt. Review of restorative plan documentation for March (after 3/24/17) and April 2017 (until 4/12/17) showed services were only documented on 4/3, 4/5, and 4/11. During an interview on 4/26/17 at 11:37 AM the DON stated the resident ambulated independently at times and CNAs would also ambulate the resident, although there was no CNA documentation to confirm. However, she stated the resident's restorative plan should have been followed.	F 311	E) Restorative staff not following restorative plans and documenting will receive immediate in servicing and corrective action will be taken. F) Results will be reported quarterly as part of the facility Quality Assurance program. Resident #1 has been discharged from the facility.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323	A) The facility will ensure interventions for fall prevention will be consistently implemented and post-fall assessments will be conducted to determine any additional interventions of any resident with a fall. B) All nurses will be educated on the importance and procedures to ensure that interventions for fall prevention will be consistently implemented and post- fall assessments will be conducted to determine any additional interventions of any resident with a fall. C) Monitoring of compliance will be done by weekly random review of two Fall Forms by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not ensuring that interventions for fall prevention are consistently implemented and post-fall assessments are not conducted	05-20-2017

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F 323	Continued From page 6 (1) Assess the resident for risk of entrapment from bed rails prior to installation (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of fall investigation documentation, the facility failed to ensure interventions for fall prevention were consistently implemented and failed to conduct a post-fall assessment to determine any additional interventions for 1 of 4 sample residents (#1) with falls. The resident had another fall which resulted in a fracture. The findings were: 1. Review of the 3/29/17 initial MDS assessment for resident #1 showed s/he required limited assistance for transfers and ambulation, and had not had any falls since admission. Review of the 3/27/17 fall risk assessment showed the resident was at risk for falls with a score of 16 (a score of 10 or higher is at risk). Review of fall investigation documentation showed the resident had a fall on 3/25/17 trying to get into the w/c. Further review showed the resident had falls on 4/1/17 and 4/4/17; in both falls, the resident's feet got tangled in the walker while ambulating or transferring. Both investigations showed the resident had a restorative program. The following concerns were identified: a. Review of the care plan dated 3/29/17 showed an intervention for fall prevention was "Strengthening thru restorative." Review of the	F 323	to determine any additional interventions 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 323	Continued From page 6 restorative therapy referral dated 3/24/17 revealed the resident had a restorative plan "to maintain mobility and walking." The plan was for ambulation 3-5 times per week with a front-wheeled walker (FWW) and gait belt. Review of restorative documentation for March (after 3/24/17) and April 2017 (until 4/12/17) showed services were only documented on 4/3, 4/5, and 4/11. During an interview on 4/26/17 at 11:37 AM the DON stated the resident ambulated independently at times and CNAs would also ambulate the resident, although there was no CNA documentation to confirm. However, she stated the resident's restorative plan should have been followed. b. Review of a nursing note dated 4/10/17 revealed the resident's family member called the nurse asking about a resident fall. The nurse was not aware of a fall. The nurse spoke to a CNA who witnessed the fall. According to the CNA and resident, the walker rolled out from underneath the resident while the resident was transferring. The resident was put on twice a day vital signs for 3 days, and the nurse inspected the walker. The walker was found to be in good condition and safe to use. Further review of the medical record and review of fall documentation showed no evidence a post-fall assessment was completed to determine potential causes for the fall and to identify any new interventions. During an interview on 4/26/17 at 12:14 PM the DON stated she was not aware of the fall until the family member voiced a grievance. She further stated it was the responsibility of the nurse to do the fall report, and she confirmed there was not a fall report for this fall. c. Review of nursing notes and fall investigation documentation showed the resident had another fall on 4/12/17. The resident stated	F 323		

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F 323	Continued From page 7 the walker got away from him/her while walking. The resident was taken to the hospital where x-rays showed a left hip fracture.	F 323		
F 406 SS=E	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(9), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure timely evaluations and failed to ensure services were provided per the written plan for 4 of 5 sample residents (#1, #2, #3, #4) who received physical therapy (PT) or occupational therapy (OT). The findings were: 1. Review of admission orders dated 3/17/17 for resident #2 revealed orders for physical therapy and occupational therapy to evaluate and treat. Review of the medical record showed the	F 406	A) The facility will ensure it provides the required rehabilitative services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs. B) Resident #1 has been discharged from the facility. C) The facility will ensure timely services are provided to residents #2, #3, #4 and all other residents who receive physical or occupational therapy. D) Physical and Occupational Therapy staff will be educated on ensuring residents receive timely services. E) Monitoring of compliance will be done by weekly random review of two residents' charting of physical therapy services by PT aide and two residents' charting of occupational therapy services by nursing supervisors using the quality improvement monitoring tool until substantial compliance has been met. F) Staff not ensuring timely therapy is provided 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.	05-20-2017

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F 406	Continued From page 8 occupational therapy evaluation was not done until 4/3/17 (17 days later). The evaluation showed the resident needed OT services one to two times per week for w/c positioning and sitting tolerance. Review of the physical therapy care plan/recertification dated 3/21/17 showed the resident was to receive PT two times per week for 8 weeks for therapeutic exercises and gait training. Review of physical therapy notes showed a PT session on 4/10/17. The next documented PT session was on 4/25/17 (15 days later). 2. Review of admission orders dated 3/16/16 for resident #1 revealed orders for PT and OT to evaluate and treat. Review of the medical record showed the OT evaluation was not done until 4/3/17 (17 days later). The evaluation indicated the resident did not need OT services. 3. Review of a 3/17/17 physician's order for resident #4 showed PT was to apply Unna Boot dressings to the bilateral lower extremities every 3 to 4 days. Review of PT progress notes showed services were provided on 4/13/17 and then on 4/19/17 (6 days later). After the 4/19/17 visit, the next documented visit was 4/25/17 (6 days later). 4. Review of the 3/28/17 care plan/recertification for PT for resident #3 revealed the resident was to receive services 2 to 3 times per week for therapeutic exercises and gait training. Review of PT progress notes showed visits on 3/29/17, 3/30/17, 4/5/17, 4/10/17, 4/13/17, and 4/18/17 (the weeks of 4/2/17 and 4/16/17 only had one visit). 5. During an interview on 4/26/17 at 11:37 AM the	F 406		

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F 406	Continued From page 9 DON stated an OT evaluation taking 2 weeks to complete from the order date was not timely. She further stated the OT department was short staffed. On 4/26/17 at 12:14 PM the DON confirmed there were no additional therapy notes for the sample residents. 6. On 5/1/17 at 8:17 AM during a telephone interview, PT #1 stated therapy did not work on weekends, therefore they used Monday to Friday for their week (to determine the number of sessions in a week). He further stated some residents would refuse services, but they did not document refusals.	F 406		