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



PRINTED: 04/20/2017
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 _____ | 04/06/2017 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys on 4/3/17 through 4/6/17.<br><br>The following common abbreviations are used throughout this document:<br><br>ADLs- Activities of daily living<br>**CAAs-** Care area assessments<br>**CNA-** Certified nurse aide<br>DON- Director of nursing services<br>LPN- Licensed practical nurse<br>MDS- Minimum Data Set<br>**MAR-** Medication administration record<br>RN- Registered Nurse<br>LDS- The Church of Jesus Christ of Latter-day Saints<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 156<br>SS=B | 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.<br><br>§483.10(g) Information and Communication.<br>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.<br><br>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing | F 156 | A)The facility will ensure information regarding resident's rights is posted on each floor.<br>B)Contact information for the State Survey Agency Home and community based programs, Adult Protective Services and the Medicaid Fraud Unit will Also be posted.<br>C)Statements have been given to every current resident on residents rights. | 05-15-17 |

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

Vicki Schow | LNHA | 5-22-17

A,ny deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting provlding 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.



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| F 156 | Continued From page 1<br>or she understands, including:<br><br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br><br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br><br>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.<br><br>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and<br><br>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. | F 156 | D)A statement will also be posted to inform residents of how to file a complaint with the State Survey Agency.<br>E)Written notice of how to apply for Medicare and Medicaid benefits will be provided to each resident on admission.<br>F)Quality monitoring of postings and written notices will be done weekly by the Social Services Director using the quality improvement monitoring tool until substantial compliance has been met.<br>G)Results will be reported quarterly as part of the facility Quality Assurance Program by the Social Services Director. | |



5/22/17 - This POC accepted w/ th agreed to changes between Traci Harrison, DON and Tony Madden, State Health Surveyor 5/23/17

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| F 156 | Continued From page 2<br><br>(li) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)<br>[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(iii) Information regarding Medicare and Medicaid eligibility and coverage;<br>[§483.10(g)(4)(li) will be implemented beginning November 28, 2017 (Phase 2)]<br><br>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a){20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase2)]<br><br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>[§483.10(g)(4}(v)will be implemented beginning November 28, 2017 (Phase2)]<br><br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the | F 156 | | |



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| F 156 | Continued From page 3<br>facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br><br>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, residentrepresentatives:<br><br>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and<br><br>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.<br><br>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. | F 156 | | |



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| F 156 | Continued From page 4<br>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.<br><br>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.<br><br>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.<br><br>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;<br><br>(g)(17) The facility must-<br><br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br><br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br><br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br><br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. | F 156 | | |



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| F 156 | Continued From page 5<br><br>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br><br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br><br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br><br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br><br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br><br>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of | F 156 | | |



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| F 156 | Continued From page 6<br>these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure information regarding resident right was posted as required. The census was 70. The findings were:<br><br>Observation on 4/5/17 at 3:32 PM revealed the facility had contact information posted for the regional ombudsman; however, there was no evidence of contact information posted for the State Survey Agency, home and community based programs, adult protective services, or the Medicaid fraud control unit. Further, there was no evidence of a posted statement informing residents of the process for filing a complaint with the State Survey Agency. Finally, there was no evidence of written information regarding how to apply for Medicare and Medicaid benefits.<br><br>Interview with the DON on 4/6/17 at 11:05 AM revealed the facility had painted the walls "several months" earlier, and she believed the postings were taken down at that time and *not* replaced. | F 156 | | |
| F 166 SS=E | 483.100)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>U)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>0)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>0)(4) The facility must establish a grievance policy | F 166 | The facility will ensure an effective process is in place to resolve grievances.<br>A)Resident #41 will be educated on her right to prompt efforts to resolve grievances. Resident #46 will be educated on his right to prompt efforts to resolve grievances. Resident #47 will be educated on her right to prompt efforts to resolve grievances. All other residents will be educated on their right to prompt efforts to resolve grievances. | 05-15-17 |



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| F 166 | Continued From page 7<br>to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymous;lythe contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entitles with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br><br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br><br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident | F 166 | B)Grievances reported by residents #41, #46, #47 have been resolved.<br>C)Residents and staff will be educated on revisions made to the facility grievance policy and procedure by the Social Services Director.<br>D)Monitoring of compliance will be done by weekly Review of the facility's grievance log by the Social Services Director weekly using the quality improvement monitoring tool until substantial compliance has been met periodically after that.<br>E)Results will be reported quarterly as part of the facility Quality Assurance Program by the Social Services Director indefinitely. | |



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| F 166 | Continued From page 8<br>right while the alleged violation is being investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of grievances, resident interview, review of policy and procedure, and | F 166 | | |



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| F 166 | Continued From page 9<br>staff interview, the facility failed to ensure an effective process was in place to resolve 3 of 4 grievances reviewed (involving residents #41, #46, #47). The findings were:<br><br>1. Review of the 3/13/17 grievance involving resident #47 showed a college student had concerns regarding treatment provided to the resident by a CNA. The grievance showed the student reported witnessing the CNA "yelling" at the resident. The concern documentation was completed by the activity director who talked with the resident and the CNA. However, there was no evidence of a thorough investigation to resolve the issue, or evidence the facility administration was aware of the allegation, which had additional reporting requirements.<br><br>2. Review of the 3/21/17 grievance involving resident #41 showed a concern the resident had regarding a CNA. The note showed the CNA was "rough" and had hurt the resident's legs that morning. The resident also stated concerns with the CNA not being responsive to toileting needs. The concern documentation showed it was completed by the social service director. The director's note failed to show a thorough investigation and failed to show the concern was resolved with the resident. In addition, there was no evidence the facility administration was aware of the allegation, which had additional reporting requirements.<br><br>3. Interview with resident #46 on 4/4/17 at 4:40 PM revealed a concern related to transportation to and from medical appointments. The resident was concerned about paying for meals and being required to eat in the facility van. According to the resident s/he had made staff aware of the | F 166 | | |



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| F 166 | Continued From page 10<br>concerns, but "it didn't go anywhere" and no resolution was achieved. Review of the facility grievances for February and Marett 2017 failed to show any grievance related to this resident.<br><br>4. Interview with the DON, nursing supervisor #1, and activity director on 4/6/17 at 9 AM verified the grievance process was not well-developed and the facility had not identified a grievance official to ensure appropriate actions were taken related to grievances. The DON verified she was made aware after resident #46's last appointment of the concerns related to the transportation. She stated there had been discussions about the issue, but nothing formal had been completed. Review of the appointment schedule showed the appointment was on 2/20/17.<br><br>5. Review of the facility's "Resident's Complaint Procedure" showed it was revised/reviewed on 7/6/16. The procedure did not designate or appoint an official who would ensure the complaint was followed through to resolution. There were various titles of staff shown that residents could present complaints to, and "If the resident chooses, the complaint may be presented to the administrator of the facility or his/her designee or staff, who shall resolve the complaint within four working days." Further review showed, "All complaints of resident abuse, neglect, and/or violation of resident rights shall be reported to the Department of Health and to the Ombudsman." | F 166 | | |
| F 167 | 483.10(g)(10)(i)(11) RIGHT TO SURVEY SS=B RESULTS- READILY ACCESSIBLE<br><br>(g)(10) The resident has the right to- | F 167 | A)The facility will ensure it posts in a readily accessible location to residents, family members and legal representatives of residents, the results of the most recent survey of the facility as well as reports with respect to any surveys, certifications , and compliant investigations made during the three | 05-15-17 |



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| NEW HORIZONS CARE CENTER | 1111 LANE 12 LOVELL, WY 82431 |

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| F 167 | Continued From page 11<br>(i) 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; and<br><br>(g)(11) The facility must-<br><br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br><br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br><br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br><br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by;<br>Based on observation and staff interview, the facility failed to ensure a notice of the availability of surveys for the preceding 3 years was posted as required. The resident census was 70. The findings were:<br><br>Observation on 4/5/17 at 3:32 PM showed the results from the most recent survey were available in a folder next to the main entrance to the facility. Further observation showed there was no notice posted to let individuals know surveys from the preceding 3 years were available for | F 167 | Preceding years along with the plans of corrections.<br>B)Residents, family members and legal representatives of residents and staff will be educated on location and availability of surveys.<br>C)The availability of the previous three years State surveys has been added to the notice of State survey results.<br>D)Monitoring of compliance will be done by weekly checks on posting to ensure it is present by supervisors using the quality improvement monitoring tool until substantial compliance has been met.<br>E)At any time posting is found not to be posted, immediate corrective action will be taken.<br>F)Results will be reported quarterly as part of the facility Quality Assurance Program. | |



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| F 167 | Continued From page 12<br>review upon request.<br><br>Interview with the DON on 4/6/17 at 11:05 AM revealed she was unaware of this requirement. | F 167 | | |
| F 225 SS=D | 483.12(a)(3)(4)(c)(1)-(4)INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.<br><br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, | F 225 | A)The facility will ensure that all alleged notations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures and documented on the grievance log.<br>B)All staff will be educated regarding appropriate abuse compliant procedures.<br>C)Monitoring of compliance will be done by weekly review of grievance log by Social Services Director until substantial compliance has been met and periodically.<br>D)Results will be reported Quarterly as part of the facility Quality Assurance Program by the Social Services Director. | 05-15-17 |



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| F 225 | Continued From page 13<br>including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of grievances, policy and procedure review, and staff interview, the facility failed to ensure 2 of 3 abuse allegations (involving residents #41, #47) were reported and investigated as required. The findings were:<br><br>1. Review of the 3/13/17 grievance involving resident #47 showed a college student had | F 225 | | |

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| F 225 | Continued From page 14<br>concerns regarding treatment provided to the resident by a CNA. The grievance showed the student reported witnessing the CNA "yelling" at the resident. The concern documentation was completed by the activity director who talked with the resident and the CNA. However, there was no evidence of a thorough investigation, or evidence the facility administration was aware of the allegation which required a report to the State Survey Agency.<br><br>2. Review of the 3/21/17 grievance involving resident #41 showed a concern the resident had regarding a CNA. The note showed the CNA was "rough" and had hurt the resident's legs that morning. The resident also stated concerns with the CNA not being responsive to toileting needs. The concern documentation showed it was completed by the social service director. The director's note failed to show a thorough investigation and failed to show the concern was resolved with the resident. In addition, there was no evidence the facility administration was aware of the allegation which required a report to the State Survey Agency.<br><br>3. Interview with the DON, nursing supervisor #1, and activity director on 4/6/17 at 9 AM concerns should have been considered allegations of abuse, and were not reported or investigated as required.<br><br>4. Review of the "Abuse Prevention Plan for Care Center and Swing Bed" showed it was revised/reviewed on 12/2/16. The plan included "All alleged violations including injuries of unknown source will be investigated as quickly and thoroughly as possible...The incident will also be reported immediately to the CEO, the State | F 225 | | |



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| F 225 | Continued From page 15<br>Ombudsman, the appropriate law enforcement officials or DFS [Department of Family Services], as well as the State Survey and Licensing Agency." | F 225 | | |
| F 248 SS=E | 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>(c) Activities.<br><br>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of activity calendars, staff and resident interviews, and medical record review, the facility failed to provide an ongoing activity program to meet the interests of residents during 4 of 4 months reviewed (January, February, March, April 2017). The census was 70. The findings were:<br><br>Review of the activities calendar for January 2017 through April 2017 showed the scheduled activities during the weekends lacked variety and enough scheduled, activities throughout the day to maintain residents' interests. Scheduled weekend activities included LDS religious services, a movie, nail clipping and music, while unscheduled activities included beauty shop and mall pass. For 12 of 17 Saturdays during this time | F248 | A)The facility will ensure that resident #46 is provided activities that are designed to meet the interests of and support the physical, mental and psychosocial well being. The facility will ensure that resident #68 is provided activities that are designed to meet the interests of and support the physical, mental and psychosocial well being. The facility will ensure that all residents are provided activities that are designed to meet the interests of and support the physical, mental and psychosocial well being of each resident.<br>B)Activity staff will be educated on having resident specific activities seven days a week.<br>C)Monitoring of compliance will be done by weekly random review of two residents activity preferences on their one to one preference sheet using the quality improvement monitoring tool until substantial compliance has been met and periodically.<br>D)Results will be reported as part of the facility Quality Assurance Program by the Activity Director. | 05-15-17 |

by the activity director



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| F 248 | Continued From page 16<br>frame the only scheduled activity was "mail pass." The following concerns were identified:<br>a. Review of the 11/3/16 annual MOS assessment showed resident #46 had diagnoses that included Parkinson's disease, anxiety, and depression. Further review showed the resident indicated reading, music, keeping up with the news, doing favorite activities, and going outside were "very important" to him. Interview on 4/4/17 at 3 PM with the resident revealed a concern related to lack of activities on weekends. The re sident stated "It's pretty dead around here," and added the only activities usually scheduled on weekends were movies. Later that day at 4:35 PM the resident added to his/her interview saying when s/he was younger s/he made leather items and s/he would like to be able to have activities that included leather crafting. Further interview with the resident on 4/5/17 at 4:35 PM revealed additional concerns with the activities program, stating the activities schedule was for women, and there was not much for men to do. The resident further revealed s/he had gained weight while at the facility "from lack of something to do."<br>b. Interview with resident #68 on 4/5/17 at 9:00 AM revealed h/she did not usually attend scheduled group activities and stated "I have gone ...get frustrated with my communication...others can't understand me." Further, the resident revealed the facility did not offer enough choices for activities thats/he would enjoy.<br>c. Interview on 4/5/17 at 3:40 PM with the activities director revealed that the staff member that had been doing weekend activities prior to January, 2017 had been scheduled as a bath aide and there wasn't sufficient staff to perform weekend activities from January through April. | F248 | | |



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| F 253<br>F 253<br>SS=E | Continued From page 17<br>483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure 3 of 4 resident areas (Pods 1/2, 3/4, and 5/6) were clean and in good repair. The findings were:<br><br>Observation on 4/5/17 at 11:32 AM showed the following areas of damaged walls and countertops in resident rooms:<br>a. The wall to the left of the armchair in room 320 had an area of peeling wallpaper measuring 15 inches by 10 inches, with the wallpaper hanging down the wall.<br>b. The wall behind the toilet in the bathroom of room 313 was gouged, exposing the drywall and creating an uncleanable surface. Additionally, there was a metal bracket sticking from the wall at approximately 40 inches from the floor, with exposed drywall behind.<br>c. The wall to the left of the door to room 311 had peeling wallpaper along the corner strip. Additionally, there was a metal bracket sticking out from the bathroom wall at approximately 40 inches from the floor, with exposed drywall behind.<br>d. The shared bathroom for rooms 307 and 308 had an approximately 4 inch strip of laminate peeling from the countertop, creating an uncleanable surface. Additionally, the wall to the left of the toilet had an area of chipped paint exposing the metal corner edging from the baseboard up approximately 12 inches. | F 253<br>F253 | A)The facility will ensure all areas of the Care Center are kept clean and in good repair.<br>B)Repairs have been made to room #320. Repairs have been made to room #313. Repairs have been made to room #311. Repairs have been made to room #307. Repairs have been made to room #308. Repairs have been made to room #218. Repairs have been made to room #219. Repairs have been made to room #224. Repairs have been made to room #229. Repairs have been made to room #230. Repairs have been made to room #240. Repairs have been made to room #241. Repairs have made to all other facility areas.<br>C)Education will be given to care center staff as well as housekeeping staff on placing work orders for maintenance to repair areas in rooms that need maintained by supervisors.<br>D)Monitoring of compliance will be done by weekly random rounds on one pod and check for needed repairs until substantial compliance has been met and periodically. by a Supervisor - ag<br>E)Any areas in rooms with needed repairs will be placed on a work order for maintenance to resolve.<br>F)Results will be reported quarterly as part of the facility Quality Assurance Program by a supervisor. | 05-15-17 |



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| F 253 | Continued From page 18<br>e. The shared bathroom for rooms 218 and 219 had areas of chipped and peeling paint around the toilet. Further, the countertop had a 14 inch long strip of laminate peeling and hanging loose from the counter and an area of missing laminate 3 inches long, exposing raw wood and creating an uncleanable surface.<br>f. The bathroom wall in room 224 had an area of chipped laminate on the bottom corner of the countertop, exposing raw wood and creating an uncleanable surface. Additionally, the wall behind the towel rack had an area of chipped paint and drywall.<br>g. The shared bathroom for rooms 229 and 230 had multiple areas of chipped paint and gouges on the walls. Additionally, the caulking along the toilet and wall was cracked and had missing areas, creating a gap and uncleanable surface.<br>h. The shared bathroom for rooms 240 and 241 had various areas of chipped and peeling paint behind the toilet.<br><br>Interview on 4/6/17 at 8:14 AM with the facility services director and DON confirmed the identified areas needed repair. They further revealed the nurses and CNAs were responsible for notifying maintenance of issues that needed to be fixed in resident rooms, and they were unaware of the identified areas of concern. | F 253 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>**483.20**<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review | F 279 | | |



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| F 279 | Continued From page 19<br>and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) 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 §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv) In consultation with the resident and the resident's representative (s)- | F279 | The facility will develop a comprehensive person centered care plan for each resident, consistent with residents rights that includes measureable objectives and timeframes to meet that residents medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment.<br>A)The facility will develop a comprehensive care plan for resident #55. The facility will develop a comprehensive care plan for all other residents.<br>B)All nursing staff and MDS team will be educated on the importance of updating care plans appropriately with new information to keep the plan current.<br>C)Monitoring of compliance will be done by weekly random review of two care plans affected by a change on disorders for that week by the MDS Coordinator using the quality improvement tool assessing for accuracy of current individualized goals, approaches and interventions for those residents until substantial compliance has been met and periodically.<br>D)Results will be reported quarterly as part of the facility Quality Assurance Program by the MDS Coordinator. | 05-15-17 |



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| F279 | Continued From page 20<br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure care plans included individualized and measurable goals, approaches and interventions for 1 of 13 sample residents (#55). The findings were:<br><br>Review of a physician's order dated 3/21/17 for resident #55 showed an order to discontinue the Foley catheter s/he had in place. On the resident's care plan, a note stated "3/21/17- d/c [discontinue] Foley per Dr. Hoffman." However, the care plan continued to have instructions for the catheter, including "1. Cath to gravity drain. 2. Cath cares every shift. 3. Flush to cath - see emar [electronic medication administration record]. 4. Resident places catheter bag on floor." There were no changes made to the care plan to address resident urinary care needs after the catheter was discontinued.<br><br>Interview on 4/4/17 at 5:25 PM with the MOS coordinator and DON revealed the process for updating the care plan when there was an order | F 279 | | |



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| F 279 | Continued From page 21<br>change affecting cares was for the nurse who took the order to change the care plan and implement appropriate actions based on the order change. The DON confirmed the resident's care plan did not address the current urinary care needs of the resident. | F279 | | |
| F280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>**483.10**<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) Jhe right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- | F280 | The facility will develop a comprehensive care plan within seven days of completion of comprehensive assessment, prepared by our Interdisciplinary Team to include a physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services, and to the extent practicable the resident and or the residents representative and periodically reviewed and revised by a team of qualified persons with each assessment.<br>A)The facility will develop a care plan based on resident needs identified thru the comprehensive assessment for resident #68. The facility will develop a care plan based on resident needs identified through the comprehensive assessment for all other residents.<br>B)The MDS Team will be educated by the MDS Coordinator on the importance of care plan development based up on the comprehensive assessment to meet resident needs.<br>C)Monitoring of compliance will be done by weekly random review of two care plans coinciding with the appropriate and triggered CAA's for that week by the MDS Coordinator using the quality improvement tool assessing for continuity between the CAA's and care plans for those two residents until substantial compliance has been met and periodically.<br>D)Results will be reported quarterly as part of the facility Quality Assurance Program by the MDS Coordinator. | |



5/22/18

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| | 535030 | A. BUILDING _____ B. WING _____ | 04/06/2017 |

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| F 280 | Continued From page 22<br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. | F 280 | | |



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| F 280 | Continued From page 23<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure a care plan was developed based on resident needs Identified through the comprehensive assessment for 1 of 13 sample residents (#68). The findings were:<br><br>Review of the 6/30/16 admission MDS assessment showed resident #68 haq diagnoses that included Parkinson's disease, was usually understood, and triggered for additional assessment in the area of communication. Review of the CAA for communication showed the re ident had "difficulty finishing words or thoughts but is able to if prompted and given time to answer. [S/he] has unclear speech such as slurred or mumbled words. [S/he] has Parkinson's and that is the cause of [his/her] communication impairment. [S/he] is at risk for not being able to express [his/her] needs." Further review showed the facility determined the area of communication would be care-planne.d The following concerns were noted:<br>a. Observation throughout the survey from 4/3/17 through 4/6/17 showed the resident spoke with very low volume or at a whisper, having to repeat him/herself to ensure the listener understood.<br>b. Interview with the resident on 4/6/17 at 9 | F280 | | |



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| F 280 | Continued From page 24<br>AM revealed s/he did not usually participate in scheduled activities. The resident stated it was due to getting frustrated because people could not understand him/her.<br>c. Review of the resident's comprehensive care plan, dated 2/16/17, showed no evidence of a communication care plan.<br>d. Interview with the activities director on 4/6/17 at 10:52 AM revealed it was her responsibility to complete the communication section of the care plan. She confirmed there was no communication care plan, adding that section should have been developed for the resident. She revealed communication strategies which worked well for the resident included speaking at the resident's eye level, allowing time for him/her to respond, and talking slowly. | F280 | | |
| F 281 SS=D | 483.21(b)(3)(i) SERVICES PROVIDED MEET **PROFESSIONAL STANDARDS**<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, and review of facility policy and procedures, the facility failed to ensure services provided by the facility met professional standards of practice for 2 of 13 sample residents (#34, #47) and 1 non-sample resident (#50). The failures related to indwelling urinary catheter care and documentation of PRN (as needed) medications. The findings were: | F 281 | A)The facility will meet professional standards of quality for resident #34. The facility will meet professional standards of quality for resident #47. The facility will meet professional standards of quality for resident #50. The facility will meet professional standards of quality for all other residents.<br>B)The facility will implement a quality monitoring tool to ensure urinary catheter bags are not placed on the floor.<br>C)Education will be provided to all nursing staff by the Infection Control Nurse on the importance of effectively implementing measures to prevent the development and transmission of infection.<br>D)Monitoring of compliance will be done by a weekly random review of two residents who have catheter drainage bags by the Infection Control nurse using the quality improvement monitoring tool until substantial compliance has been met and periodically.<br>E)Results will be reported quarterly as part of the facility Quality Assurance Program by the Infection Control Nurse. | 05-15-17 |



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| F 281 | Continued From page 25<br><br>1. The following concerns regarding catheter care were identified:<br>a. Observation on 4/4/17 at 11:37 AM showed resident #34 was sitting in a recliner chair in the resident common area on the second floor. The resident had a urinary catheter bag, placed inside a cloth bag, which was laying on the floor. CNA #3 used a sit-to-stand lift to transfer the resident to a wheelchair. While using the lift, the CNA used the catheter bag hanger to hang the bag on the hydraulic arm of the lift, placed at shoulder height to the resident. The bag remained on the arm of the lift throughout the transfer. The CNA did not don gloves during the handling of the catheter bag and tubing.<br>b. Observation on 4/4/17 at 11:41 AM showed resident #50 was sitting in a recliner chair in the resident common area on the second floor. The resident had a urir,ary catheter bag, which was placed inside a cloth bag at the side of the chair. CNA #3 used a sit-to-stand lift to transfer the resident to a wheelchair. While using the lift, the CNA used the catheter bag hanger to hang the bag on the hydraulic arm of the lift, placed at shoulder height to the resident. The bag remained on the arm of the lift throughout the transfer. The CNA did not don gloves during the handling of the catheter bag and tubing.<br>c. Interview on 4/6/17 at 8:38 AM with the infection control nurse revealed that the expectation for urinary catheter care was the catheter bag and tubing should not be on the floor, and should not be raised above the bladder. Further, handwashing should have occurred after touching the catheter bag and tubing.<br>d. Review of the policy and procedure titled "urinary catheter care", last revised 12/5/16, stated in the general guidelines "4. The urinary | F 281 | | |



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| F 281 | Continued From page 26<br>drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder" and "11. Be sure the catheter tubing and drainage bag are kept off the floor."<br><br>2. Review of the 3/16/17 quarterly MOS assessment showed resident #47 had diagnoses that included chronic pain. Further review showed the resident reported pain, with a highest intensity of 8/10, and also received a hypnotic medication. Review of the 3/9/17 pain assessment showed the resident reported severe pain and received both scheduled and PRN pain medications. Review of the physician's orders showed the resident was prescribed hydromorphone 2 mg "take one to two tablets four times daily as needed," and temazepam (hypnotic) 7.5 mg at bedtime as needed. Review of the care plan, dated 3/16/17, showed the patient was at risk for alteration in comfort related to leg and shoulder pain, and had a goal of "Reports pain level of 6 when assessed bid [two times a day] over the next 90 days." Interventions included medications as ordered, rice packs, elevate feet, repositioning, and assessing pain two times a day. The following concerns were identified:<br>a. Review of the MAR for March 2017 showed the resident received PRN hydromorphone 61 times. Review of the MAR for 4/1/17 through 4/5/17 showed the resident received PRN hydromorphone 12 times. There was no evidence of a pain level being assessed prior to administration, or follow up on the effectiveness of the medication. Review of the nursing notes for March and April 2017 showed the resident frequently requested pain medications related to shoulder pain and pain | F 281 | A)Resident #47 will have follow-up evaluations with PRN pain or hypnotic medications to determine effectiveness of the medication. All other residents receiving PRN pain or hypnotic medication will have follow-up evaluations to determine effectiveness of the medication.<br>B)Education will be provided to all nursing staff on the importance of evaluating and documenting effectiveness of PRN medications by the CNO.<br>C)Monitoring of compliance will be done by weekly random review of two PRN pain medications and two PRN hypnotic medication using the quality improvement monitoring tool until substantial compliance has been met and periodically.<br>D)Results will be reported quarterly as part of the facility Quality Assurance Program by a supervisor. | |



5/23/17

PRINTED: 04/20/2017
FORM APPROVED
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| F 281 | Continued From page 27<br>from a coccyx wound. There was no evidence of a pain level being assessed, or follow up to assess the effectiveness of the pain medications.<br>b. Review of the MAR for March 2017 showed the resident received PRN tamazepam on 28 days. Review of the MAR for 4/1/17 through 4/5/17 showed the resident received PRN tamazepam on 5 days. Review of the nursing notes for March and April 2017 revealed a note dated 3/29/17, timed 10:07 PM, that showed "resident requesting sleeping aide at this time, tamazepam 7.5 mg capsule given." There was no additional documented evidence to support the administration of tamazepam, or an assessment of its effectiveness.<br>c. Interview with the DON on 4/6/17 at 11:15 AM confirmed the documentation did not show the resident's pain was being assessed prior to administering PRN pain medications, or that there was follow up to assess the effectiveness of the medications. She further revealed her expectation was for the nurse to follow up on the effectiveness of PRN medications as a way of monitoring their necessity.<br>d. Review of the policy and procedure titled "Medication Administration-General Guidelines," not dated, showed: "Documentation... 5) When PRN medications are administered, the following documentation is provided... b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted..."<br>e. According to "Lippincott Nursing Procedures," Seventh Edition, 2013: "Safe Medication Administration Practices, General... Monitor and document the effectiveness of all medications administered..." | F 281 | | |
| F 309 | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES | F 309 | | |

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OMB NO 0938-0691

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| F 309 SS=D | Continued From page 28<br>FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview, | F 309 | A)The facility will provide care and services for the highest well being of resident #47. The facility will provide care and services for the highest well being of all other residents.<br>B)Resident #47 and all other residents will receive a pain level assessment before medication administration and as a follow-up to pain medication administration.<br>C)Education will be provided to all nursing staff on the importance of evaluating and documenting effectiveness of PRN pain medications by the CNO.<br>D)Monitoring of compliance will be done by weekly random review of two PRN pain medications for documentation using the quality improvement monitoring tool ~~until substantial compliance has been~~ met and periodically.<br>E)Results will be reported quarterly as part of the facility Quality Assurance Program by a supervisor. | 05-15-17 by the Supervisor |



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| F 309 | Continued From page 29<br>and review of professional standards, the facility failed to ensure effective pain management consistent with professional standards and the resident's care plan for 1 of 8 sample residents (#47) with pain. The findings were:<br><br>Review of the 3/16/17 quarterly MOS assessment showed resident #47 had diagnoses that included chronic pain. Further review showed the resident reported frequently occurring pain with a highest intensity of 8/10 which affected sleep and participation in daily activities. Additionally, the resident received scheduled, PRN, and non-medication interventions for pain. Review of the physician's orders showed the resident was prescribed hydromorphone 2 mg "take one to two tablets four times daily as needed." Review of the care plan, dated 3/16/17, showed the patient was at risk for alteration in comfort related to leg and shoulder pain, and had a goal of "Reports pain level of 6 when assessed bid [two times a day] over the next 90 days." Interventions included medications as ordered, rice packs, elevate feet, repositioning, and assessing pain two times a day. The following concerns were identified:<br>a. Review of the MAR for March 2017 showed the resident received PRN hydromorphone 61 times. Review of the MAR for 4/1/17 through 4/5/17 showed the resident received PRN hydromorphone 12 times. There was no evidence of a pain level being assessed prior to administration or follow up on the effectiveness of the medication.<br>b. Review of the nursing notes for March and April 2017 showed the resident frequently requested pain medication related to shoulder pain and pain from a coccyx wound. There was no evidence of a pain level being assessed or follow up to assess the effectiveness of the pain | F 309 | | |



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| F 309 | Continued From page 30<br>medications.<br>c. Further review of the March and April 2017 MARs and nursing notes showed no documentation of attempts at the non-pharmacological interventions for pain identified on the resident's care plan, including repositioning or rice packs.<br>d. Interview with the DON on 4/6/17 at 11:15 AM confirmed the documentation did not show the resident's pain was being assessed prior to administering PRN pain medications, or that there was follow up to assess the effectiveness of the medications. She further revealed her expectation was for a pain level and follow up to be completed and documented.<br>e. According to "Lippincott Nursing Procedures," Seventh Edition, 2013: "Pain Management... Reassess pain in a timely manner according to the onset of the prescribed medications. Ensure that your assessment is comprehensive and appropriate to the circumstances (type of pain, level of intervention, and care setting) to ensure the safety and efficacy of care... Describe the subjective information you elicited from the patient, using his own words. Note the location, quality, and duration of the pain as well as precipitating factors. Record the pain-relief method selected and the patient's rating of the pain before and after pain management interventions..." | F 309 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and | F 323 | A)Supervisors will ensure the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.<br>B)The facility will develop a quality monitoring tool to ensure oxygen cylinders are not left free-standing in an upright position.<br>C)Education will be provided to all staff on the danger of leaving oxygen cylinders free-standing in | 05-15-17 |



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| F 323 | Continued From page 31<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(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.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's **size** and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and policy and procedure review, the facility failed to ensure a portable oxygen cylinder was maintained in a safe and secure manner during one random observation. The findings were:<br><br>Observation on 4/3/17 at 5:42 PM in the pod 7/8 dining area revealed RN #2 changing the oxygen cylinder for a resident. While removing the empty oxygen cylinder, the full cylinder was free-standing in an upright position directly on the floor behind a resident's wheelchair. The dining area had 14 residents and 4 staff members in it while the cylinder was unsecured.<br><br>Interview on 4/6/17 at 8:38 AM with the DON revealed it was the expectation for oxygen | F 323 | an upright position by supervisors.<br>D)Monitoring of compliance will be done by weekly random monitoring of the facility for oxygen cylinder placement using the quality monitoring tool until substantial compliance has been met and periodically.<br>E)Results will be reported quarterly as part of the facility Quality Assurance Program by supervisors. | by the supervisor. |



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| F 323 | Continued From page 32<br>cylinders to be transported using a wheeled cart and not be standing unsecured directly on the floor.<br><br>Review of the facility's policy and procedure for cardiopulmonary services and oxygen, last revised 7/6/16, stated in the precautions section "All oxygen cylinders must be placed in a transport cylinder cart or securely fastened to a surface by a chain to prevent the cylinder(s) from falling over and becoming a projectile, which could cause injury/death to residents or staff." | F 323 | | |
| F 356 SS=B | 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census. | F 356 | A)The facility will post nurse staffing information containing all of the appropriate requirements specified in paragraph (g) (1) on a daily basis in a prominent place readily accessible to residents and visitors.<br>B)All staff will be educated on the importance of posting all required staffing information by supervisors.<br>C)Monitoring of compliance will be done by weekly random review of two At-A-Glances using the facility quality monitoring tool until substantial compliance has been met and periodically.<br>D)Results will be reported quarterly as part of the facility Quality Assurance Program by supervisors. | 05-15-17 |

By 9 Supervisor - AM



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| F 356 | Continued From page 33<br>(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents and visitors.<br><br>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure that nurse staffing information was posted in a manner that met all requirements for 5 of 5 days (April 1-5, 2017) reviewed. The findings were:<br><br>Review of the posted nurse staffing information sheets for April 1-5, 2017 revealed staff names and positions **(RNs,** LPNs and **CNAs)** were shown for each shift; however, the total number of hours for each position were not posted for each shift. Further, the name of the facility was not listed on the staffing information sheet. Interview with the DON on 4/6/17 at 9:00 AM | F 356 | | |



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| F 356 | Continued From page 34<br>revealed the facility was not aware of these requirements. | F 356 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(1)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a sanitary environment in 3 of 3 food preparation/storage areas (main kitchen, pod 2 kitchen, and the East dining room). These failures related to hand washing, monitoring dish machines, condition of food equipment, and prevention of contamination of | F 371 | A)The facility will ensure a sanitary environment in main kitchen, pod 2 kitchen, East dining room and all other food prep/storage areas in accordance with standards established in the current edition of FDA food code and that dishwasher sanitizing levels are appropriate.<br>B)All dietary staff will be educated on the importance of utilizing hand hygiene to ensure a sanitary environment is maintained in the main kitchen by the Dietary Manager.<br>C)Fans in main kitchen have been cleaned and will be placed on a cleaning schedule. Plastic blenders have been replaced.<br>D)Monitoring of compliance will be done by weekly by the Dietary Manager rounding to ensure kitchen and equipment are sanitary and maintained and hand hygiene is performed as needed using the quality improvement monitoring tool until substantial compliance has been met.<br>E)Equipment in poor condition will be replaced.<br>F)Results will be reported quarterly as part of the facility Quality Assurance Program by the Dietary Manager.<br>G)Staff will be educated on the importance of ensuring the dining/kitchen areas are kept clean and sanitary by supervisors.<br>H)Monitoring of compliance will be done by weekly rounds checking facility food preparation areas for cleanliness as well as dishwasher sanitizing level checks by Assisted Living Manager.<br>I)Results will be reported quarterly as part of the facility Quality Assurance Program by supervisors. | |



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| F 371 | Continued From page 35<br>clean articles. The findings were:<br><br>1. Observation in the main kitchen showed the following concerns:<br>a. On 4/5/17 at 5:20 PM dietary aide #1 was placing items onto resident meal trays. Within a 3 minute time frame the aide handled the door to the walk-in refrigerator and the walk-in freezer on 3 occasions and with no hand hygiene continued to handle the food and equipment for resident meals.<br>b. On 4/3/17 at 4:38 PM and on 4/5/17 at 4:30 PM, 2 fans were observed to be blowing on clean dishes. One was located near the three-compartment sink and the other in the clean side of the dish room. The fans were soiled with a thick build-up of dust and lint.<br>c. On 4/3/17 at 4:38 PM observation showed 2 plastic blenders with cracks and fissures in the plastic. Observation of a bin containing clean bowls showed at least 6 were in poor condition with damage to the plastic on the interiors of the bowls.<br>d. Interview with the certified dietary manager on 4/6/17 at 8:30 AM confirmed the need for hand washing after handling the refrigerator/freezer doors. She also verified the equipment was old and needed to be replaced. Further, she confirmed the fans were in need of cleaning<br><br>2. Sanitation concerns in the East dining room kitchen:<br>a. Observation on 4/3/17 at 4:36 PM showed a dishwasher was located in the area and contained dishes. Interview with the registered dietitian (RD) and the activity director on 4/5/17 at 9:14 AM verified there was no monitoring to ensure the dish machine was achieving a level of sanitation. The two staff members also revealed | F 371 | | |



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| F 371 | Continued From page 36<br>the machine was not used frequently, maybe once per week. The machine was tested on 4/5/17 and review of the thermolabel showed the machine had reached 160 degrees Fahrenheit at the plate surface.<br>b. Observation on 4/3/17 at 4:36 PM showed the microwave oven located in the East dining room kitchen was soiled with dried on food. The microwave remained in the same condition when observed on 4/5/17 at 9:14AM. At this time the RD verified it was in need of cleaning<br><br>3. Sanitation concerns in the pod 2 kitchen:<br>a. Observation on 4/5/17 at 2:09 PM showed this kitchen also contained a dish machine. The dish machine was out of service during the survey. However, interview with the RD and the activity director on 4/5/17 at 9:14 AM verified there was no monitoring to ensure the dish machine was achieving a level of sanitation. They reported the dish machine had been out of service for approximately 3 weeks.<br>b. Observation on 4/5/17 at 2:09 PM showed the microwave oven in this kitchen was soiled with dried on food. At that time the RD also saw the condition and confirmed the microwave needed to be cleaned.<br><br>4. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands."<br><br>5. According to Food Code 2013, U.S. Public Health Service:4-501.112 "The temperature of | F 371 | | |



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| F 371 | Continued From page 37<br>hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least 71°C (160°F) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90°C (194°F) at the manifold, the water becomes volatile and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 74°C (165°F) for a stationary rack, single temperature machine, and 82°C (180°F) for other machines are based on the sanitizing rinse contact time required to achieve the 71°C (160°F) utensil surface temperature."<br><br>6. According to Food Code 2013, U.S. Public Health Service, 4-903.11 "**(A)** Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored:<br>(1) In a clean, dry location;<br>(2) Where they are not exposed to splash, dust, or other contamination; and<br>(3) At least 15 cm (6 inches) above the floor. | F 371 | | |
| F 441 SS=E | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention | F 441 | A)The facility will ensure Infection Control standards including a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases and written standards, policies and procedures for resident #34 are followed. The facility will ensure Infection Control standards including a system for preventing, identifying, reporting, investigation, and controlling | 05-15-17 |



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| F 441 | Continued From page 38<br>and control program (IPCP) that must include, at a minimum, the following elements :<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. | F 441 | infections and communicable diseases and written standards, policies, and procedures for resident #50 are followed. The facility will ensure Infection Control standards including a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases and written standards, policies, and procedures for resident #17 are followed. The facility will ensure Infection Control standards including a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases and written standards, policies, and procedures for all other residents are followed.<br>B)All nurses and Certified Nursing Assistants will be educated on the importance of following infection control standards by the Infection Control Nurse.<br>C)Monitoring of compliance will be done by weekly random review of two residents being transferred with a lift that have indwelling urinary catheters, two residents receiving inhalers, two residents requiring oxygen therapy, and two residents during meal observations by a supervisor using the quality improvement monitoring tool until substantial compliance has been met and periodically.<br>D)Results will be reported quarterly as part of the facility Quality Assurance Program by supervisors. | |



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| F 441 | Continued From page 39<br><br>(v) The circumstances under which 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; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of facility policy and procedure, the facility failed to ensure infection control standards were followed for 2 of 2 residents (#34, #50) with indwelling urinary catheters, during 1 of 1 random medication pass observations, 1 of 1 random oxygen therapy observations (#17), and during 1 of 2 meal observations. This deficient practice created a risk of cross contamination and transmission of infection. The findings were:<br><br>1. Observation on 4/4/17 at 11:37 AM showed resident #34 was sitting in a recliner chair in the resident common area on the second floor. The resident had a urinary catheter bag, which was placed inside a cloth bag, which was laying on the | F 441 | | |



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| F 441 | Continued From page 40<br>floor. CNA#3 used a sit-to-stand lift to transfer the resident to a wheelchair. While using the lift, the CNA used the catheter bag hanger to hang the bag on the hydraulic arm of the lift, placed at shoulder height to the resident. The bag remained on the arm of the lift throughout the transfer. The CNA did not don gloves during the handling of the catheter bag and tubing, and was observed coughing into her right hand and touching the resident and catheter bag and tubing. Further, the CNA proceeded to assist the next resident without sanitizing her hands between residents or cleaning the sit-to-stand lift.<br><br>2. Observation on 4/4/17 at 11:41 AM showed resident #50 was sitting in a recliner chair in the resident common area on the second floor. The resident had a catheter bag, which was placed inside a cloth bag at the side of the chair. CNA#3 used a sit-to-stand lift to transfer the resident to a wheelchair. While using the lift, the CNA used the catheter bag hanger to hang the bag on the hydraulic arm of the lift, placed at shoulder height to the resident. The bag remained on the arm of the lift throughout the transfer. The CNA did not don gloves during the handling of the catheter bag and tubing. Once the resident was in his/her wheelchair, the CNA pushed the resident in his/her wheelchair to the dining table, and placed a clothing protector around the resident's neck. There was no hand sanitation between the tasks of transferring the resident, handling the catheter bag, and placement of the clothing protector. Further, the sit-to-stand lift was not sanitized after its use.<br><br>3. Observation on 4/4/17 at 9:36 PM showed RN #1 was administering medications to a resident in a resident room. A purple inhaler device was on | F 441 | | |



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| F 441 | Continued From page 41<br>the fall mat beside the bed. The RN picked the inhaler up off the fall pad, exited the room, and first laid the device on top of the medication cart, then placed it into a drawer in the cart. The inhaler was not cleaned after being on the fall mat. Interview with the RN at that time identified the medication as an Advair Diskus inhaler.<br><br>4. Observation on 4/4/17 at from 9:43 AM showed a resident #17 had a nasal cannula (oxygen delivery tubing) with the nasal prongs faced downward lying on a fall mat in his/her room. At 10:17 AM CNA#4 entered the room, picked the nasal cannula off the floor and placed the nasal prongs into the residents nostrils and secured the tubing in place behind his/her ears. The tubing was not cleaned or replaced after lying on the fall mat.<br><br>5. Observation on 4/3/17 at 5:30 PM showed CNA #1 and CNA#2 were serving evening meal trays to multiple residents without using proper hygiene. At 5:40 CNA#1 washed her hands, but then scratched her nose and put her hair behind her ear on 3 occasions while she continued to pass resident meal trays. During the service she handled the resident's trays, and opened drinks and salad dressing packets. Observation of CNA #2 at 5:47 PM showed she opened a drink box with her thumb without wearing gloves. Her thumb pierced through the container and made contact with the contents. She then poured the drink into the resident's glass.<br><br>6. Interview on 4/5/17 with CNA#3 revealed, she wiped the sit-to-stand lifts down "whenever it starts to get dirty," such as when the lift had "spots, poo on it or was smelly." | F 441 | | |



5/29/17

PRINTED: 04/20/2017
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/CUA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535030 | A. BUILDING _____ B. WING _____ | 04/06/2017 |

| 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 441 | Continued From page 42<br>7. Interview on 4/6/17 at 8:38 AM with the infection control nurse confirmed it was the expectation of the facility that the Advair Diskus inhaler should have been cleaned with a sanitizing wipe after it had been on the fall mat. She confirmed the nasal cannula tubing that had been on the fall mat should have been thrown away and replaced with a new one. She confirmed the sit-to-stand lifts would fall under the patient care equipment category of "common equipment" which should be cleaned and disinfected between residents. Further, she confirmed the expectation for Foley catheter care was the catheter bag and tubing should not be on the floor, and should not be raised above the bladder.<br><br>8. Review of the policy and procedure titled "standard precautions," last revised 12/17/16, stated under the category of patient care equipment "If common equipment is used, clean and disinfect between patients." Under the category of when to wash hand and wear gloves, the policy stated "Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Wash immediately after removing gloves and between patienUresident contacts. Avoid transfer of microorganisms to other patients or environments."<br><br>9. Review of the policy and procedure titled "urinary catheter care," last revised 12/5/16, stated in the general guidelines "4. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder" and "11. Be sure the catheter tubing and drainage bag are kept off the floor." | F 441 | | |



5/23/17

PRINTED: 04/20/2017
FORM APPROVED
OMB NO 0938-0391

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

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| NEW HORIZONS CARE CENTER | 1111 LANE 12 LOVELL, WY 82431 |

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|---|---|---|---|---|
| F 465 SS=D | 483.90(i)(5) SAFE/FUNCTIONAUSANITARY/COMFORTABL E ENVIRON<br><br>(i) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure a comfortable and sanitary environment in 1 of 1 dish rooms. The findings were:<br><br>Observation on 4/3/17 at 4:38 PM and 4/5/17 at 4:30 PM of the dish room showed the entire wall under the counter on the dirty side was soiled with accumulated dried food and debris. The wall adjacent to this counter was also soiled with the same type of debris. Additionally, there was a large vent located above the dish machine which was soiled with a thick accumulation of gray dust/lint. The gray dust/lint was also visible on the walls and the ceiling in the dirty side of the dish room. Interview with the certified dietary manager on 4/6/17 at 8:30 AM revealed the cleaning required assistance from the maintenance department. She also revealed when she asked the maintenance director the last time the vent was serviced, he told her it was 6/20/16. | F465 | A)The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.<br>B)The dish room walls, ceiling and vent above the dish machine will be cleaned monthly by the Dietary Manager.<br>C)Dietary staff will be educated on ensuring dish room is kept clean according to schedule.<br>D)Monitoring of compliance will be done by weekly random rounds to check dish room by Dietary Supervisor using the quality improvement monitoring tool until substantial compliance has been met and periodically.<br>E)Results will be reported quarterly as part of the facility Quality Assurance Program by the Dietary Manager. | |



5/29/17