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 _____	06/27/2019

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 recertification survey was conducted by Healthcare Licensing and Surveys on 6/24/19 through 6/27/19. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		8/7/19

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

Electronically Signed | 07/19/2019

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F 600	Continued From page 1 Based on medical record review, staff interview, and policy and procedure review, the facility failed to protect residents from abuse for 1 of 5 sample resident (#53) who were involved in abuse allegations. The findings were: Review of the 5/22/19 behavior monitoring documentation showed resident #64 was physically aggressive to resident #53. The note showed "...[s/he] punched [resident #64] in the face and knocked [him/her] to the ground." There were no additional details regarding possible injuries on the behavior monitoring documentation, however, review of the 5/25/19 timed at 3:11 AM nurse's note showed resident #53 had bruising noted on his/her "...left hip from waistline down to the mid-thigh region. It is unknown when or how this injury occurred." Review of the undated fall committee meeting minutes showed resident #53 was reviewed for the injury and it was determined to be a result of the incident when the resident was "pushed by an external force." The following concerns were identified: a. Review of the records failed to show a report or investigation was done related to the physical abuse. b. Review of the medical record failed to show a nursing assessment was completed related to the bruising identified on the resident on 5/25/19. c. Interview on 6/26/19 at 10:33 AM with RN #2 and RN #3 revealed there were no reports made or investigations done related to the resident to resident altercations.	F 600	A.)The facility will ensure that resident #53 will be protected from abuse, neglect, misappropriation of resident property, and exploitation as well as all residents of the facility. B.)All staff will receive education on the policy titled, "Abuse Prevention Program" and the importance of reporting any type of abuse. C.)Quality monitoring on protecting residents from abuse will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not protecting residents from abuse and neglect will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	

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F 600	Continued From page 2 d. Review of the undated facility policy and procedure titled "Resident-To-Resident Altercation" showed "...k. Report incidents, findings, and corrective measures to appropriate agencies outlined in our facility's abuse reporting policy." Review of the 2/13/19 revised "Abuse Prevention Plan for Care Center and Swing Bed" showed requirements for reporting and investigation which included "...7...While protecting the welfare of all residents, reports of abuse are investigated immediately and reported to the appropriate authorities..." The policy went on to show the State Survey Agency was included as an agency required to be notified.	F 600		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, 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.	F 609		8/7/19

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F 609	Continued From page 3 §483.12(c)(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. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, policy and procedure review, and staff interview, the facility failed to report allegations of abuse for 5 of 5 allegations reviewed (involving residents #3, #40, #47, #53, #64 and #67). The findings were: 1. Review of the 5/22/19 behavior monitoring documentation showed resident #64 punched resident #53 in the face and knocked him/her to the ground. Review of the 5/25/19 timed at 3:11 AM nurse's note showed resident #53 had bruising noted on his/her "left hip from waistline down to the mid-thigh region. It is unknown when or how this injury occurred." Review of the undated fall committee meeting minutes showed resident #53 was reviewed for the injury and it was determined to be a result of the incident when the resident was "pushed by an external force." Further review showed there was no report made to the survey agency regarding the resident-to-resident altercation. 2. Interview with resident #40 on 6/24/19 at 5:30 PM revealed s/he was "upset" with how RN #1 treated him/her related to a situation with cleaning the resident's CPAP machine. The resident explained on or around 6/10/19 RN #1 "got mad" with the resident when the nurse heard from another nurse what the resident had stated about	F 609	A.)The facility will ensure that allegations of abuse, neglect, exploitation or mistreatment involving residents #3, #40, #47,#53, #64 and #67 will be reported, as well as all residents of the facility. B.)All staff will receive education on the policy titled, "Abuse Investigation and Reporting" and the importance of reporting any type of abuse. C.)Quality monitoring on reporting allegation of abuse will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not reporting allegations of abuse will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	

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F 609	Continued From page 4	F 609		

RN #1 not completing the cleaning of his/her CPAP machine and "being lazy." The resident stated RN #1 confronted him/her about what was said and refused to clean the machine any further. The resident was "upset" and thought it was "unfair." At that time, the resident revealed s/he had not reported how s/he felt about the way s/he was treated. Interview with the DON on 6/24/19 at 6:30 PM revealed she was aware of a situation that involved the resident and RN #1. She stated the nurse had documented a note; however, there was not a report of alleged abuse or an investigation related to the situation at that time. The following concerns were identified:

a. Review of the 6/16/19 timed at 7:55 PM nurse's note showed RN #1 documented "...At that point, I did inform [the resident] I did not appreciate what [s/he] said to [the other nurse]. I informed the resident that I made a point to do extra things for [him/her] and so it hurt my feelings that [s/he] would say that. Resident stated "I don't care." "I informed the resident that it is our job to help [him/her] do things [s/he] could not do for [him/herself], so from now on, since [s/he] doesn't care, I would only help [him/her] with the things that [s/he] could not do [him/herself]. Again, resident stated "I don't care." I informed the resident that [s/he] could now clean [his/her] CPAP [him/herself] as [s/he] was not happy with the way we do it anyway. Resident stated that [s/he] would not clean the CPAP [him/herself] because s/he was told [s/he] shouldn't have to do it. I informed the resident [s/he] was capable so it is [his/her] responsibility."

b. Interview with RN #2 and the DON on 6/25/19 at 9:30 AM revealed they reported the allegation of abuse and had begun an investigation after the surveyor reported to them on 6/24/19.

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F 609	Continued From page 5	F 609		

3. Review of nursing notes showed on 6/2/19 at 7:15 PM it was documented a CNA witnessed an altercation between resident #67 and #47. Resident #47 grabbed the wrist of resident #67 and held it tight for a minute before the resident pulled loose. The nurse further documented there was a purplish discoloration to the left wrist on resident #67, from the base of the thumb extending 2-3 cm up to the wrist.

4. Review of the 6/14/19, timed at 7:12 PM nurse's note showed resident #47 was involved in an incident with an unknown resident. The resident "went to peer and grabbed [her/his] arm very tightly. This nurse intervened and redirected. The resident shortly went back to the same resident and [was] hitting walker to walker, intervention [was] done by this nurse and both CNAs." Interview on 6/26/19 at 2:22 PM with the resident care director and RN #3 revealed they could not find any further documentation to show the identity of the other resident that was involved.

5. Review of nursing progress notes showed on 10/12/18 resident #3 hit another resident. The notation showed, "Resident walked up to a fellow resident who was standing there not bothering anyone, and punched fellow resident in [his/her] side. Fellow resident is unharmed. Told fellow resident, "I'm gonna get you" and then hit [him/her] in the side." Interview on 6/27/19 at 9:37 AM with RN #2 revealed there was no other documentation available about the incident, and the facility did not know the identity of the other resident who was involved.

6. Interview on 6/26/19 at 10:33 AM with RN #2

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F 609	Continued From page 6 and RN #3 revealed there were no reports made or investigations done related to these resident to resident altercations. 7. Review of the undated facility policy and procedure titled "Resident-To-Resident Altercation" showed "k. Report incidents, findings, and corrective measures to appropriate agencies outlined in our facility's abuse reporting policy." Review of the 2/13/19 revised "Abuse Prevention Plan for Care Center and Swing Bed" showed requirements for reporting and investigation which included "7..."While protecting the welfare of all residents, reports of abuse are investigated immediately and reported to the appropriate authorities..." The policy went on to show the State Survey Agency was included as an agency required to be notified.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(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	F 610		8/7/19

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F 610	Continued From page 7 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of medical records, resident interview, policy and procedure review, and staff interview, the facility failed to investigate allegations of abuse for 5 of 5 allegations reviewed (involving residents #3, #40, #47, #53, #64, and #67). The findings were: 1. Review of the 5/22/19 behavior monitoring documentation showed resident #64 punched resident #53 in the face and knocked him/her to the ground. Review of the 5/25/19 timed at 3:11 AM nurse's note showed resident #53 had bruising noted on his/her "left hip from waistline down to the mid-thigh region. It is unknown when or how this injury occurred." Review of the undated fall committee meeting minutes showed resident #53 was reviewed for the injury and it was determined to be a result of the incident when the resident was "pushed by an external force." Further review showed there was no investigation done related to the resident-to-resident altercation. 2. Interview with resident #40 on 6/24/19 at 5:30 PM revealed s/he was "upset" with how RN #1 treated him/her related to a situation with cleaning the resident's continuous positive airway pressure (CPAP) machine. The resident explained around 6/10/19 RN #1 "got mad" with the resident when the nurse heard from another nurse what the resident had stated about RN #1 not completing the cleaning of his/her CPAP machine and "being lazy." The resident stated RN #1 confronted him/her about what was said and refused to clean the machine any further. The resident was "upset" and thought it was "unfair." At that time,	F 610	A.)The facility will ensure that allegations of abuse, neglect, exploitation, or mistreatment involving residents #3,#40,#47,#53,#64 and #67 will be investigated, as well as all residents of the facility. B.)All staff will receive education on the policy titled, "Abuse Investigating and Reporting" and the importance of investigating, preventing and correcting alleged violations of abuse. C.)Quality monitoring on investigating, preventing and correcting alleged violations against residents will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not investigating, preventing and correcting alleged violations against residents will receive immediate in-service and corrective actions will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	

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F 610	Continued From page 8	F 610		

the resident revealed s/he had not reported how s/he felt about the way s/he was treated. Interview with the DON on 6/24/19 at 6:30 PM revealed she was aware of a situation that involved the resident and RN #1. She stated the nurse had documented a note; however, there was not a report of alleged abuse or an investigation related to the situation at that time. The following concerns were identified:

a. Review of the 6/16/19 timed at 7:55 PM nurse's note showed RN #1 documented "...At that point, I did inform [the resident] I did not appreciate what [s/he] said to [the other nurse]. I informed the resident that I made a point to do extra things for [him/her]and so it hurt my feelings that [s/he] would say that. Resident stated "I don't care." "I informed the resident that it is our job to help [him/her] do things [s/he] could not do for [him/herself], so from now on, since [s/he] doesn't care, I would only help [him/her] with the things that [s/he] could not do [him/herself]. Again, resident stated "I don't care." I informed the resident that [s/he] could now clean [his/her] CPAP [him/herself] as [s/he] was not happy with the way we do it anyway. Resident stated that [s/he] would not clean the CPAP [him/herself] because [s/he] was told [s/he] shouldn't have to do it. I informed the resident [s/he] was capable so it is [his/her] responsibility."

b. Interview with RN #2 and the DON on 6/25/19 at 9:30 AM revealed they reported the allegation of abuse and had begun an investigation after the surveyor reported to them on 6/24/19.

3. Review of nursing notes showed on 6/2/19 at 7:15 PM it was documented a CNA witnessed an altercation between resident #67 and #47. Resident #47 grabbed the wrist of resident #67

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F 610	Continued From page 9	F 610		

and held it tight for a minute before the resident pulled loose. The nurse further documented there was a purplish discoloration to the left wrist on resident #67, from the base of the thumb extending 2-3 cm up to the wrist.

4. Review of the 6/14/19, timed at 7:12 PM nurse's note showed resident #47 was involved in an incident with an unknown resident. The resident "went to peer and grabbed [her/his] arm very tightly. This nurse intervened and redirected. The resident shortly went back to the same resident and [was] hitting walker to walker, intervention [was] done by this nurse and both CNAs." Interview on 6/26/19 at 2:22 PM with the resident care director and RN #3 revealed there was no additional information and they could not identify the other resident that was involved.

5. Review of nursing progress notes showed on 10/12/18 resident #3 hit another resident. The notation showed, "Resident walked up to a fellow resident who was standing there not bothering anyone, and punched fellow resident in [his/her] side. Fellow resident is unharmed. Told fellow resident, "I'm gonna get you" and then hit [him/her in the] side." Interview on 6/27/19 at 9:37 AM with the RN #2 revealed there was no investigation information available for the incident, and the facility could not identify the other resident who was involved.

6. Interview on 6/26/19 at 10:33 AM with RN #2 and RN #3 revealed there were no reports made or investigations done related to these resident-to-resident altercations.

7. Review of the undated facility policy and procedure titled "Resident-To-Resident

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F 610	Continued From page 10 Altercation" showed "k. Report incidents, findings, and corrective measures to appropriate agencies outlined in our facility's abuse reporting policy." Review of the 2/13/19 revised "Abuse Prevention Plan for Care Center and Swing Bed" showed requirements for reporting and investigation which included "7..."While protecting the welfare of all residents, reports of abuse are investigated immediately and reported to the appropriate authorities..." The policy went on to show the State Survey Agency was included as an agency required to be notified.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		8/7/19

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F 623	Continued From page 11	F 623		

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

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F 623	Continued From page 12 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a written transfer notice was provided for 1 of 1 sample residents (#67) who was transferred to the emergency room. The findings were: Review of a post-fall evaluation dated 5/21/19	F 623	A.)The facility will ensure that resident #67 and residents representative and all other residents and their representative are notified of the transfer or discharge and the reasons for the move in writing and a language and manner they understand. The State Ombudsman will	

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F 623	Continued From page 13 showed resident #67 was found in the hallway on 5/20/19 at 11:15 PM and was bleeding from the head. The resident was sent to the hospital and treated in the emergency room. Review of a nursing note dated 5/21/19 revealed the resident returned from the emergency room. A progress note dated 5/21/19 at 7 AM showed the resident's son was notified of the fall and the emergency room visit. Further review of the medical record showed no evidence of a transfer notice. On 6/26/19 at 2:26 PM the resident care director stated the family was notified verbally that the resident went to the emergency room, but that written notice of the transfer was not provided.	F 623	be notified of all transfers and discharges as well B.)All staff will be educated on the importance of providing a written notice of transfer with all transfers. C.)Quality monitoring on written notices of transfer will be done weekly by a designated supervisor of all transfers using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff not providing written notice will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a designated supervisor.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		8/7/19

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F 625	Continued From page 14 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written information on the bed-hold policy for 1 of 1 sample residents (#67) who was transferred to the emergency room. The findings were: Review of a post-fall evaluation dated 5/21/19 showed resident #67 was found in the hallway on 5/20/19 at 11:15 PM and was bleeding from the head. The resident was sent to the hospital and treated in the emergency room. Review of a nursing note dated 5/21/19 revealed the resident returned from the emergency room. A progress note dated 5/21/19 at 7 AM showed the resident's son was notified of the fall and the emergency room visit. Further review of the medical record showed no evidence information on the bed-hold policy was provided to the family. On 6/26/19 at 2:26 PM the resident care director stated the family was notified verbally that the resident went to the emergency room, but that information on the bed hold policy was not provided.	F 625	A.)The facility will ensure that resident #67 and representative and all other residents and their representative will be provided written information before a transfer of the bed-hold policy. B.)All staff will receive education on the policy titled, "Bed Holds and Returns" and the importance of providing written information on the bed-hold policy. C.)Quality monitoring of bed hold notices will be done weekly by a designated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff not issuing a bed hold policy upon transfer will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a designated supervisor.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		8/7/19

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F 656	Continued From page 15 §483.21(b)(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 - (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 (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). (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 16 section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to develop a care plan for needed areas for 1 of 18 sample residents (#67). The findings were: Review of the 3/6/19 significant change MDS assessment showed resident #67 wandered 1 to 3 days per week and the wandering intruded on the privacy of others. Review of a social services evaluation dated 6/13/19 showed the resident could be uncooperative and wandered. Review of a 5/16/19 provider progress note showed the resident had severe cognitive impairment and wandered throughout the facility. On 6/24/19 at 5:36 PM the resident was observed to go into another resident's room (room 303). On 6/26/19 at 12:13 PM the resident was observed coming out of another resident's room (room 322). Review of the care plan provided by the facility on 6/26/19 revealed interventions to address wandering were not identified. During an interview on 6/27/19 at 9 AM, the MDS coordinator, the resident care director, and RN #2 and RN #4 confirmed the care plan did not identify specific interventions to address wandering.	F 656	A.)The facility will ensure that resident #67 and all other residents will have a comprehensive person-centered care plan for each resident consistent with the resident rights developed. B.)All staff will receive education on the policy titled, "Care Plans, Comprehensive Person-Centered" and the importance of developing a care plan. C.)Quality monitoring on comprehensive care plans will be done weekly by a delegated supervisor using the quality monitoring improvement tool until substantial compliance has been met. D.)Any staff member not developing a comprehensive person-centered care plan will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a designated supervisor.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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	F 684		8/7/19

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F 684	Continued From page 17 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to complete a nursing assessment for 1 of 2 sample residents (#53) who had injuries. The findings were: Review of the 5/22/19 behavior monitoring documentation showed resident #64 was physically aggressive to resident #53. The note showed "...[s/he] punched [resident #64] in the face and knocked [him/her] to the ground." There were no additional details regarding possible injuries. Review of the 5/25/19 timed at 3:11 AM nurse's note showed resident #53 had bruising noted on his/her "left hip from waistline down to the mid-thigh region. It is unknown when or how this injury occurred." Review of the undated fall committee meeting minutes showed resident #53 was reviewed for the injury and it was determined to be a result of the incident when the resident was "pushed by an external force." The following concerns were identified: a. Review of the medical record failed to show a nursing assessment was completed after the resident-to-resident altercation that included physical aggression to resident #53. b. Review of the medical record failed to show a nursing assessment was completed related to the bruising identified on the resident on 5/25/19. c. Interview with RN #3 on 6/27/19 at 9 AM verified she was unable to locate any documentation of nursing assessments for these two instances.	F 684	A.)The facility will ensure that resident #53 and all other residents will receive treatment and care in accordance with professional standards of practice including a nursing assessment after an incident or accident. B.)All staff will receive education on the policy titled, "Accidents and Incidents-Investigating and Reporting" and the importance of completing a nursing assessment after an incident or accident. C.)Quality monitoring on nursing assessments after an incident or accident will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not completing a nursing assessment after an incident or accident will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	

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F 689	Continued From page 18	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to provide adequate supervision and implement interventions for 1 of 2 sample residents (#67) who wandered. The findings were: 1. Review of the 3/6/19 significant change MDS assessment showed resident #67 had two falls since the last assessment, had a BIMS score of 3 (indicating severe cognitive impairment), and was independent with transfers and walking in the room. In addition, the resident wandered 1 to 3 days per week and the wandering intruded on the privacy of others. Review of the care area assessments for cognition, behavioral symptoms and falls revealed the resident had a diagnosis of Alzheimer's dementia and frequently wandered. Review of a social services evaluation dated 6/13/19 showed the resident could be uncooperative and wandered. Review of a 5/16/19 provider progress note showed the resident had severe cognitive impairment and wandered throughout the facility. Review of a post-fall evaluation dated 4/27/19 showed on 4/27/19 at 4:20 PM the resident was in another resident's room and tripped over his/her feet and	F 689	A.)The facility will ensure that resident #67 and all residents will receive adequate supervision to prevent accidents and have interventions for wandering implemented. B.)All staff will receive education on the policy titled, "Wandering, Unsafe Resident" and the importance of providing adequate supervision and implementing interventions for residents who wander. C.)Quality monitoring on adequate supervision for wandering residents will be done weekly by supervisors using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not providing adequate supervision for wandering residents will received immediate in-service and corrective actions will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	8/7/19

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F 689	Continued From page 19	F 689		

slid to the floor. The following concerns were identified:

a. Review of the care plan provided by the facility on 6/26/19 revealed interventions to address wandering were not identified. Interventions for falls included "hourly rounds" and "wanders- know whereabouts."

b. On 6/24/19 at 5:36 PM the resident was observed to go into another resident's room (# 303) when the resident (#47) was in the room. Review of nursing notes showed on 6/2/19 the resident and resident #47 were involved in an altercation, where resident #47 grabbed the wrist of the resident.

c. On 6/25/19 at 9:03 AM CNA #1 was asked where the resident was, because s/he wasn't in his/her room or the common area. The CNA replied the resident walked in the halls and usually found somebody else's bed to sleep on.

d. On 6/25/19 at 9:13 AM the doors to the secure care unit (SCU) were open, and the resident was in the common area on the other side of the second floor (pods 7/8).

e. On 6/25/19 at 11:45 AM CNA #2 asked CNA #3 where the resident was. The CNA stated the resident was probably sleeping on somebody else's bed. CNA #2 then went room to room in the SCU to look for the resident. The resident was not in the SCU. The CNA then went to pods 7/8 (the SCU doors were open) and started going room to room to locate the resident. The CNA found the resident on the bed of resident #64 in room #345. The CNA was unable to get the resident to leave the room, so she got CNA #4 to help her. They were unable to get the resident to leave. CNA #4 commented resident #64 would not be happy, so she approached the resident at the dining room table and told him/her another resident was in his/her bed, and they would try to

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F 689	Continued From page 20	F 689		

get the resident to leave in a few minutes. During an interview on 6/26/19 at 4:29 PM the resident confirmed another resident had been in his/her bed.

f. On 6/26/19 at 12:13 PM the resident was observed coming out of another resident's room (room 322). The resident had a white substance on his/her face. The resident then went into his/her own room. At 12:19 PM CNA #5 went into the resident's room, after the surveyor told the CNA the resident had a white substance on his/her face, and said the white substance was toothpaste. The CNA assisted the resident to the toilet, and then cleaned the resident's face. The CNA stated at that time the resident was a "really bad wanderer" and went into other residents' rooms. The CNA then went into room 322 and saw urine and BM in the toilet, and stated the resident had used the other resident's toilet.

g. During an interview on 6/26/19 at 3:22 PM LPN #1 stated the resident was one to worry about because s/he went into other resident rooms. She stated there were more residents on the other side (pods 7/8) that would be upset if s/he went into their rooms. When asked what interventions staff used for wandering, she stated they try to redirect, but that rarely worked. She stated the resident did what the resident wanted and s/he looked for a place to sleep or go to the bathroom. She also stated when the resident was in somebody's bed, it sometimes took two staff to get him/her out.

h. On 6/27/19 at 9 AM the MDS coordinator, the resident care director, and RN #2 and RN #4 were all interviewed. When asked what specific interventions they used to address wandering, they stated to keep an eye on him/her, know his/her whereabouts, and maybe redirect. However, they confirmed the care plan did not

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F 689	Continued From page 21 identify specific interventions to address wandering. When asked if they had documentation to show interventions tried, and evidence of re-evaluation of interventions to determine effectiveness, they stated no. They agreed the resident was at risk for altercations due to going into other resident's rooms. When asked why the resident was placed in the SCU, they replied it was for wandering. When asked what the criteria was for the SCU doors being open at times, they stated there was no criteria. If things were calm and there were no behaviors, they would leave the doors open. They stated there was no assessment for wandering to determine risk for elopement or altercations, or how opening the SCU doors could impact the risks of the resident's wandering.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		8/7/19

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F 690	Continued From page 22 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure urinary catheter bags were kept below the level of the bladder for 1 of 4 sample residents (#37) with urinary catheters. The findings were: 1. Review of the annual MDS assessment dated 4/25/19 showed resident #37 had a BIMS score of 8/15 (moderately impaired), had diagnoses which included urinary tract infection (UTI) in last 30 days, diabetes mellitus, cerebrovascular accident (CVA), hemiplegia, and neurogenic bladder, had an indwelling catheter, and required extensive assistance for transfers and toileting. The following concerns were identified: a. Observation of care for the resident on 6/25/19 at 8:55 AM showed staff moved the resident from his/her wheel chair to a recliner using a full mechanical lift. While transferring the resident, CNA #6 picked up the catheter bag and	F 690	A.)The facility will ensure that resident #37, as well as all other residents will receive appropriate treatment and services to prevent urinary tract infections. B.)All staff will receive education on the policies titled, "Urinary Continence and Incontinence-Assessment and Management" and "Urinary Catheters, Use of and Prevention of CAUTI" and the importance of appropriate treatment and services to prevent urinary tract infections. C.)Quality monitoring for ensuring that urinary catheter bags are kept below the level of the bladder will be done continuously by all supervisors documenting on the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not keeping catheter bags below the level of the bladder will receive immediate in-service and	

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F 690	Continued From page 23 held it above the resident's shoulder for 4 minutes. The urine in the tubing was noted to return to the resident's bladder. b. Interview with CNAs #3 and #5 on 6/26/19 at 2:25 PM revealed it was expected of the staff to hook the catheter bag to the knee bar on the lift when transferring a resident. c. Interview with the infection preventionist on 6/27/19 at 9:01 AM revealed the expectation was to keep the drainage bag below the bladder. 2. Review of the "Urinary Catheter Care" policy and procedures last revised 8/22/18 showed ...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...	F 690	corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		8/7/19

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 _____	06/27/2019

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

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F 732	Continued From page 24 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(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. §483.35(g)(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: Based on observation, staff interview, and family interview, the facility failed to have posted, in a readable readily accessible format, the complete daily licensed nurse staffing information for 20 out of 20 days reviewed (6/7/19 to 6/27/19). The findings were: In interview with the family of resident #58 on 6/25/19 at 11:11 AM they denied seeing or knowing about nurse staffing information being posted. Observation on 6/27/19 at 8:30 AM showed the clipboard with the nurse staffing information was located on the desk behind the privacy wall at the downstairs nursing station. The information was not posted and also failed to contain the number of licensed staff per required discipline (CNA, LPN, RN). The last 20 days reviewed showed only the total number of hours worked for each discipline was documented.	F 732	A.)The facility will ensure that the complete daily licensed nurse staffing information is posted in a readable readily accessible format. B.)All staff will be educated on the policy titled, "Posting Direct Care Daily Staffing Numbers" and the importance of posting the complete daily licensed nurse staffing information. C.)Quality monitoring for posting the daily licensed nurse staffing information will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found not posting the daily licensed nurse staffing information will receive immediate in-service and corrective action will be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

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F 732	Continued From page 25 Interview on 6/27/19 at 12:30 PM with the resident care director revealed she was unaware of these requirements for the postings.	F 732	E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced	F 755		8/7/19

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 _____	06/27/2019

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NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

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F 755	Continued From page 26 by: Based on observation, staff interview, and review of manufacturer instructions, the facility failed to ensure medications available for use were not expired in 1 of 3 storage areas (secure unit 2nd floor medication cart). The findings were: 1. Observation of the secure unit 2nd floor medication cart on 6/26/19 at 2:35 PM showed Victoza 18 mg/3 ml flex pen (insulin injection pen) with no written open date. Interview at that time with LPN #1 confirmed there was no open date, and the medication was available for use. 2. Interview with RN #5 on 6/26/19 at 3:30 PM confirmed the facility expectation would be to label the insulin pen with the 28 day expiration. 3. Review of manufacturer's instruction found at www.victoza.com/faq/Using-the-Victoza-Pen.html (retrieved 7/1/19) showed open Victoza insulin injection pens could be used for up to 30 days.	F 755	A.)The facility will ensure that pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. B.)All staff will receive education on the policy titled, "Administering Medications" and the importance of ensuring medications available for use are not expired. C.)Quality monitoring on expired medications will be done weekly by a delegated supervisor using the quality improvement monitoring tool until substantial compliance has been met. D.)Any staff found using expired or unlabeled expiration dated medications will receive immediate in-service and corrective action will be taken. E.)Results will be reported quarterly as part of the facility quality assurance program by a delegated supervisor.	