STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0019	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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S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 A licensure survey was conducted by Healthcare Licensing and Surveys from 6/24/19 to 6/27/19.	S 000		
S3048	Ch 11 Sec 20 (a)(i) Grievance Investigations (a) Each Nursing Care Facility shall establish a system of reviewing allegations of violations of residents' rights and develop internal operating procedures for reporting and resolution. (i) In order to ensure that residents continue to be aware of these rights and responsibilities, a written copy is to be prominently posted in a location that is available to all residents. This State Rule and Regulation 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 establish and implement an effective system for investigating and reporting 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	S3048	A.)The facility will ensure that there is an effective system for reviewing allegation of violations of residents' rights and develop internal operating procedures for reporting and resolution for residents #3, #40, #47, #53, #64 and #67 and all residents of the facility. B.)All staff will receive education on the policy titled, "Abuse Investigation and Reporting", education on the grievance process and the importance of reporting and resolution.	8/7/19

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S3048	Continued From page 1 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, 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	S3048	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 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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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 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

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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 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

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S3048	Continued From page 4 required to be notified.	S3048		