STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING _____ B. WING _____	C 08/02/2019

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 complaint survey was conducted by Healthcare Licensing and Surveys on 08/02/19. The survey was prompted by complaint intakes WY000002898 and WY000002901. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing 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: Based on medical record review, observation, staff interview, review of employee training	F 600	A.)The facility will ensure that resident #1 will be protected from abuse, neglect,	8/7/19

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

Electronically Signed | 08/20/2019

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F 600	Continued From page 1 records, review of the State Survey Agency incident reporting logs, and review of facility investigation documentation, the facility failed to ensure residents were free from abuse for 2 of 6 abuse allegations (both involving resident #1) reviewed. This failure resulted in harm to resident #1, who sustained bruising. The findings were: Review of the 5/8/19 MDS assessment showed resident #1 was admitted to the facility on 1/31/19, and had diagnoses that included Alzheimer's disease and depression. The resident had severely impaired cognitive skills for daily decision making, was rarely or never understood, and rarely or never understood others. The resident was totally dependent on staff assistance with dressing and eating, and required extensive staff assistance with bed mobility, transfers, and toilet use. The resident was coded as having physical, verbal, and other behaviors 1 to 3 days during the 7-day look-back period. Further, the resident did not receive anti-coagulant medication. The following concerns were identified: 1. Review of the State Survey Agency reporting logs showed a 7/28/19 incident, reported by the facility on 8/1/19, with an allegation of abuse. The incident report showed an allegation CNA #4 "...grabbed [the resident]and told [him/her] to 'shut the fuck up.'" Further review showed the facility had contacted the Department of Family Services (DFS), and "DFS will completing (sic) this investigation and we are awaiting the outcome of that investigation." Interview with CNA #3 on 8/2/19 at 5 PM revealed she had witnessed the alleged abuse. The CNA stated on 7/28/19 around 4:15 PM the resident	F 600	misappropriation of resident property, and exploitation as well as all residents of the facility. B.)Certified Nursing Assistant's #1, #4 and 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 delegated supervisor.	

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F 600	Continued From page 2	F 600		

was "...yelling, crying and [CNA #4] was jerking on [the resident's] arm to get [her/him] out of bed and telling [him/her] to shut up." CNA #4 then "threw" the resident hard into the wheel chair.

Observation on 8/2/19 8:45 AM showed the resident had three round bruises of a deep purple color, consistent with finger imprints, that measured approximately 1 centimeter each and were located on the right arm just above the elbow. Interview with CNA #2 on 8/2/19 at 2:55 PM revealed "There weren't any bruises there Friday [7/26/19] during [the resident's] shower, but there sure were on Monday [7/29/19]."

Interview with the DON on 8/2/19 at 2:30 PM revealed CNA #4 had been placed on suspension pending the outcome of facility and DFS investigations.

During a phone interview on 8/2/19 at 5:50 PM CNA #4 revealed she didn't "...know why they called and told me not to come to work." The CNA volunteered she had completed a one-person transfer of the resident over the weekend, and stated, "It was not the smoothest transfer." Additionally, the CNA stated "[Resident #1] is very vocal and gets on everyone's nerves."

Review of the online educational record for CNA #4 showed "Abuse and Restraints" training was completed on 10/31/18.

2. Review of the State Survey Agency incident reporting logs showed a 7/20/19 incident, reported by the facility on 7/22/19, with an allegation of abuse. The incident report showed RN #1 told the facility the resident had a history of crying and moaning, but had not been crying

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F 600	Continued From page 3	F 600		

much in the morning or during the earlier part of the day on 7/20/19. CNA #1 got the resident up for dinner, and at that time, the resident was crying and moaning. The RN provided the resident with pain medication, and asked CNA #1 to feed the resident ice chips, as that was know to calm the resident and help him/her stop crying. The CNA responded she didn't understand why, because "...it wouldn't do any good." While assisting with feeding the ice chips to the resident, the CNA stated "I can't stand this [man/woman]." This was said in front of the resident and in a public area. The report showed the facility interviewed the CNA, and she admitted to making the statements. The CNA received a three day suspension, would no longer be working with the resident, and was scheduled to attend abuse training.

Review of the nursing note dated and timed 7/20/19 at 4:30 PM showed RN #1 assigned CNA #1 to feed the resident ice cubes. The RN reported CNA #1 stated that "she didn't understand why because it wouldn't do any good", and then later stated "I can't stand this [man/woman]." This was spoken "in front of resident and in a public area". Further, the note showed these statements upset the resident.

Interview with RN #1 on 8/02/19 at 10:34 AM confirmed the CNA said "she didn't understand why because it wouldn't do any good" and "I can't stand this [man/woman]." The RN further stated the resident was visibly upset by the statement.

During a phone interview with CNA #1 on 8/2/19 11:20 AM she acknowledged that she made the statements. She further acknowledged she knew it was a violation to do so, but stated "no way the

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F 600	Continued From page 4 resident could have even heard me." Review of the online educational record for CNA #1 showed "Abuse and Restraints" training was completed on 10/31/18.	F 600		