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 10/27/2021

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 10/26/21 to 10/27/21. The survey was prompted by complaint intakes WY00003304, WY00003305, and WY00003299 In addition, a focused infection control survey was conducted by Healthcare Licensing and Surveys on 10/26/21 to 10/27/21. It was determined, based upon the findings of the survey team, that no deficiencies were identified related to the infection control survey.	F 000		
F 610 SS=D	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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, review of the facility's incident report, and policy and procedure review, the facility failed to ensure	F 610	A.)The facility will ensure that all alleged violations of abuse are thoroughly investigated for all residents and will	12/1/21

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

Electronically Signed | 11/15/2021

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F 610	Continued From page 1 a thorough investigation of abuse allegations, and failed to ensure protection for 1 of 1 allegations (involving resident #11) made between 8/1/21 and 10/26/21 . The findings were: 1. Review of the 9/29/21 quarterly minimum data set (MDS) assessment revealed resident #11 was admitted to the facility on 1/18/21 with diagnoses that included Alzheimer's disease and depression. Further review showed the resident was severely cognitively impaired, with a brief interview for mental status (BIMS) score of 5 of 15. Continued review showed the resident required total dependence of two staff members for bed mobility, and extensive assistance of two staff members for transfers and toilet use. The following concerns were identified: a. Interview with certified nurse aide (CNA) #1 on 10/27/21 at 11:25 AM revealed during shift change on the night of 10/19/21 at approximately 10:30 PM, she needed assistance with resident #11, who had crawled out of bed and was seated on the floor towards the center of the room. She requested the help of CNA #2, and noted CNA #2 appeared very grouchy and irritated at that time. She stated they entered the room, and before she could help, CNA #2 walked over behind the resident, stated "We are not doing this shit tonight!", grabbed the resident under his/her arms, dragged the resident back over to his/her bed, lifted him/her up, and sat him/her on the edge of the bed without the assistance of CNA #1. At that point the resident stated s/he needed to use the restroom. CNA #1 further stated CNA #2 positioned the resident's wheelchair next to the bed, and again grabbed the resident under his/her arms and lifted him/her into the chair without the assistance of CNA #1. The two staff	F 610	prevent potential abuse, neglect, or mistreatment while investigation is in process. Facility will also report the results of all investigations to administrator or his or her designated representative and to all other officials in accordance with State law, including State Survey Agency, within five working days of the incident and if alleged violation is verified appropriate corrective action will be taken for all residents including #11. B.)All staff will receive re-education on policy titled, "Abuse Investigation and Reporting" and the importance of investigating, preventing, and correcting alleged violations of abuse. All staff will be re-educated on investigation flow sheets to ensure accurate documentation. All supervisors will also be educated on policy and what to do when called about alleged abuse. All staff will be educated on preventing abuse by our Education Coordinator, Hiedi Christensen. C)Quality monitoring on investigating, preventing, and correcting alleged violations against residents will be done monthly by Social Services Director using quality improvement monitoring tool until substantial compliance has been met. D)Any staff not investigating, preventing, and/or correcting alleged violations against residents per policy will receive immediate in-service and corrective action will be taken.	

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F 610	Continued From page 2 members then took the resident to the bathroom and transferred him/her to the toilet. When the resident had finished, the resident attempted to stand up from the toilet him/herself, insisting s/he wanted to try and perform the task him/herself. CNA #1 stated CNA #2 was standing back against the wall and making abrasive comments to the resident at that time, stating " ... come on, if you can do it then just stand up! " CNA #1 then assisted the resident to standing position, performed perineal care, and guided the resident back to his/her wheelchair. CNA #1 stated CNA #2 wanted to put the resident back into bed, but CNA #1 stated she "... did not think that was a good idea or safe after watching how [CNA #2] was acting ..." CNA #1 then brought the resident out to the common area, near the area where staff gave report. At that time, the resident was visibly agitated and upset, and began expressing his/her frustrations in Spanish. CNA #3, who spoke Spanish, noticed how upset the resident was, approached the resident, and attempted to calm him/her down. CNA #3 translated and stated to the staff present in the area the resident stated s/he was "... being thrown around like a rag doll by the girl in blue scrubs ..." CNA #3 then asked the resident in Spanish who was "...throwing [him/her] around?" and the resident pointed at CNA #2. b. Interview with CNA #3 on 11/8/21 at 11:07 AM revealed on the night of 10/19/21, she had just come on shift and was awaiting report at approximately 10:45 PM, and observed CNA #1 and CNA #2 bringing resident #11 to the common area where she was waiting. CNA #3 stated she noticed the resident was visibly very upset, and expressing herself in Spanish. She further stated the resident was saying s/he wanted to go back to his/her room, and " ... all I wanted to do was go	F 610	E)Results will be reported quarterly as part of the Quality Assurance Program Improvement Program by Social Services Director.	

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F 610	Continued From page 3	F 610		

pee. " She further stated the resident expressed " ... I want to go to bed but the girl in blue threw me around like a rag doll ... " and continued to ask why s/he was in the common area and not in his/her room. CNA #3 then retrieved a snack and juice for the resident in an attempt to calm him/her down. CNA #3 stated after getting the snacks, she wanted to take the resident to a different area to help deescalate the situation. Upon turning the wheelchair around, the resident noticed CNA #2 standing in the area, pointed at her stating "That's the girl throwing me around like a rag doll!", and began getting upset again. CNA #3 then took the resident away from the area, and after CNA #1 finished giving report, the two staff members toileted the resident and put him/her to bed.

c. Review of the resident's medical record showed no documentation referencing the allegation, no documentation of vital signs or an assessment of the resident had been performed. Review of the facility's incident report regarding this allegation showed no evidence any assessment had been made of the resident.

d. Interview with registered nurse (RN) #1 on 11/3/21 at 7:14 PM revealed he came to the unit close to shift change, and observed CNA #2 who "... seemed very upset and agitated, and heard her say she was 'sick of this shit!'" as she walked through the unit. He stated after passing some medications, he returned to the common area and observed a group of CNAs having "... an intense discussion ..." After completing a few more tasks, he stated he was approached by CNA #1 and informed of the incident. RN #1 further stated that while staff were giving report, resident #11 was in the common area very upset, and was talking to CNA #3 in Spanish. Further, when CNA #3 began to wheel the resident out of

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the area, the resident was expressing things in Spanish and strongly pointing at CNA #2. He stated he notified the on-call supervisor, and was directed to have CNA #1 file a complaint on behalf of the resident. Further interview revealed he did not perform an assessment of the resident after the alleged incident occurred, and was not directed to do so by the on-call supervisor when he notified her. He also stated he was not directed to make staffing adjustments, did not make any himself, and CNA #2 was still allowed to care for the resident after the alleged incident had occurred.

e. Review of facility document "Investigation Flowsheet Staff to Resident Abuse, Neglect, or Misappropriation of Resident Property" for this incident, which was undated showed the incident was "...reported to supervisor and the nurse said apparently stated [sic] that [the resident] didn't want [CNA #2] taking care of [him/her]. Supervisor wasn't aware of the abuse allegations."

f. Review of the facility policy entitled Abuse Prevention Program, last reviewed 8/15/19, showed " ...residents have the right to be free from abuse ... This includes but is not limited to freedom of corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse ... " Further review showed " ... the administration will: Protect our residents from abuse by anyone including ... facility staff, other residents consultants, volunteers staff from other agencies, family members, legal representatives, friends, visitors, or any other individual ... Identify and assess all possible incidents of abuse ... Protect residents during abuse investigations. "