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	535030	A. BUILDING _____ B. WING _____	C 01/09/2025

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

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/6/25 through 1/9/25. Also reviewed in the course of the survey was complaint intake WY00004025. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant DON: Director of Nursing RN: Registered Nurse MDS: Minimum Data Sheet BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578		1/30/25

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

Electronically Signed | 02/03/2025

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and facility policy and procedure review, the facility failed to ensure residents right to request/refuse/discontinue treatment for 1 of 1 sample residents (#45) with a do not resuscitate (DNR) status. The findings were: 1. Review of the electronic medical record on 1/7/25 at 2:26 PM showed resident #45 had a DNR code status, however there was no evidence the resident elected the DNR code status. 2. Interview with the DON on 1/9/25 at 10 AM revealed the electronic medical record showed no	F 578	A) Facility will ensure residents' right to request/refuse/discontinue treatment for all residents with a do not resuscitate (DNR) status is followed. Resident representative for resident #45 was contacted by Social Services DIrector and the WyoPOLST (Wyoming Provider Order of Life Sustaining Treatment) was discussed and filled out appropriately. WyoPOLST form is scanned into resident's medical record with the appropriate signatures including physician's signature. Physician code status order reflects the decision made during the conversation with resident	

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F 578	Continued From page 2 sign of a declaration of code status. Further interview revealed the provider should have filled out the code status; however, it was not in the electronic medical record. 3. Review of the facility's policy "DNR Policy" updated 3/15/18 showed "...1. At the time of admission the Social Services person or Charge Nurse shall determine if the resident has executed a Living Will or has a signed statement for DNR. ...5. The physician shall assume the responsibility for writing the DNR order by: a. Writing and dating the order on the Physician's order sheet b. The order will be updated every 30 days and signed by the Physician. 6. If the resident is mentally incompetent (determined by a Physician), the resident's guardian and/or the Durable POA for health care decisions (designated by the Living Will or by written statement from the resident prior to the mental incompetency) may make the DNR designation."	F 578	representative. For all future admitted residents will participate in discussion of resident's wishes for life sustaining treatment. If a resident has an exisiting POLST or written advanced directive stating life sustaining treatment wishes on file, the documentation will be reviwed with resident and/or resident representative and documented in the admitting documentaiton. "DNR Order" facility policy will be updated with the changes to comply with this regulation. B) All nurses, managers and physicians will receive education on appropriate documentation and paperwork for discussions regarding advanced directives accompanying associated physician orders. Education will include facility policy "DNR Order." C) Quality monitoring on advanced directives order and documentation will be done on all current residents, with each admission, and changes in advanced directive by Social Services Director using the quality improvement monitoring tool until substantial compliance has been met. D) Staff will receive immediate in-service and correction action will be taken for any advanced directive documentation found to be out of compliance. E) Results will be reported quarterly as part of the facility's qualty assurance program by the Social Services Director.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		1/30/25

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F 677	Continued From page 3 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure residents received services to maintain good personal hygiene for 2 of 3 sample residents (#7, #33) reviewed for activities of daily living. The findings were: 1. Review of the quarterly MDS assessment dated 10/1/24 showed resident #7 had a BIMS score of 14 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included cerebrovascular accident, transient ischemic attack, or stroke and Parkinson's disease. Further review showed the resident required partial/moderate assistance with bathing and upper and lower body dressing. The following concerns were identified: a. Interview with the resident on 1/7/25 at 9:21 AM revealed s/he did not feel there was enough staff because s/he did not get showers regularly. b. Review of the bathing records for October, November, and December of 2024 and January of 2025 showed the resident went 6 days without a shower from 10/18/24 to 10/25/24, 11/22/24 to 11/29/24, 12/6/24 to 12/13/24, and 12/13/24 to 12/20/24. Further review showed the resident went 10 days without a shower from 12/27/24 to 1/7/25. There were no documented refusals for the resident. 2. Review of the quarterly MDS assessment dated 10/22/24 showed resident #33 had a BIMS score of 15 out 15, which indicated the resident	F 677	A) Facility will ensure residents receive services to maintain good personal hygiene as part of activities of daily living. Bathing schedule has been evaluated and any barriers for baths being provided have been identified. If a bath aide is not availalbe, residents will be offered a bathing alternative such as shower or bed bath. The offering of bathing alternatives will be documented appropriately on bathing logs. Refusals of alternatives will be documetned on the bathing log, as well. "Resident Baths" facility policy will be updated with changes to comply with this regulation. B) All staff will receive education on alternative changes for bathing and providing good personal hygiene in the instance that a bath aide is not scheduled or available and the appropriate documentation necessary. Education will include facilty policy "Resident Baths." C) Quality monitoring on offering of bathing, shower, or bed bath with appropriate documentation will be done weekly by Resident Care Manager using the quality improvement monitioring tool until substantial compliance has been met. D) Staff will receive immediate in-service and correction action will be taken for any residents bathing and personal hygiene is found to be out of compliance. E) Results will be reported quarterly as	

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F 677	Continued From page 4 was cognitively intact, and had diagnoses which included Parkinson's disease. Further review showed the resident required partial/moderate assistance with bathing and lower body dressing. The following concerns were identified: a. Interview with the resident on 1/7/25 at 11:03 AM revealed the facility only offered showers 2 days per week and at times s/he did not receive a shower because there was not enough staff. b. Review of the bathing records for October, November, and December of 2024 and January of 2025 showed the resident went 6 days without a shower from 10/1/24 to 10/9/24, for 9 days from 10/15/24 to 10/25/24, for 10 days from 10/25/24 to 11/5/24, for 6 days from 11/8/24 to 11/15/24, for 9 days from 11/19/24 to 11/29/24, for 6 days from 12/6/24 to 12/13/24 and 12/13/24 to 12/20/24, and for 10 days from 12/27/24 to 1/7/25. Further review showed the resident refused bathing on 10/4/24, 10/18/24, 10/29/24, 11/12/24, and 11/22/24 and there was no evidence the resident was offered bathing on another day. 3. Interview with the DON on 1/8/25 at 4:24 PM revealed residents should get at least 1 shower per week and ideally would have 2 showers per week. She confirmed showers were only provided on scheduled days and the facility did not have a plan to ensure bathing when the staff member who provided bathing was not available. 4. Review of the facility policy titled "Resident Baths" last revised on 6/15/18 showed "...All residents will receive a full-body bath at least once a week. An exception to this may be made if the resident is so ill that it would not be in their best interest to insist. For residents who are ill or unable to tolerate the tub or shower bath, a bed	F 677	part of the facility's quality assurance program by the Resident Care Manager.	

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F 677	Continued From page 5 bath is an acceptable substitute...3. All residents will be bathed more frequently as the desire, or if soiling has occurred that requires a tub bath or shower...10. We recognize that all residents have the right to refuse baths, clothing changes, and other measures of good hygiene. If any resident chooses not to accept these services, the CNA will inform the nurse in charge of that resident's care, of the refusal. The nurse will then have the responsibility of persuading the resident to accept care. If the resident still adamantly refuses the bath, the nurse will document in the resident's chart. Offers for the bath will be continued until the resident will accept...12. Residents will be scheduled for baths on two days per week, as has been the practice. If residents refuse a bath on one day, or if the care center staffing does not allow for baths on one of those days, it may be postponed until the next shift, the next day, or the next scheduled bath day. All schedules and cares give must always be in the best interest of care and comfort for the resident..."	F 677		
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	F 690		1/30/25

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F 690	Continued From page 6 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 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 an appropriate diagnoses and attempt removal of an indwelling urinary catheter for 1of 1 sample resident (#7). The findings were: 1. Review of the quarterly MDS assessment dated 10/12/24 showed resident #7 had a BIMS score of 14 out 15, which indicated the resident was cognitively intact, and no genitourinary diagnoses except renal insufficiency, renal failure, or end-stage renal disease. Further review showed the resident was independent with toileting hygiene, personal hygiene, and toilet transfer, was always continent of bowel, was not	F 690	A) Facility will address Resident #7's indwelling catheter by consulting with primary care physician (PCP) for appropriate use for indwelling catheter. Upon assessment, PCP found that resident has no control of his bladder or urinary incontinence indicating a neurogenic bladder and the necessary use of an indwelling catheter to care for resident's chronic wounds to his bilateral lower extremities. Facility will ensure that residents have the appropriate diagnosis indicating the need for an indwelling catheter and documented attempt of removal of an indwelling catheter in the instance of a resident who is admitted or	

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F 690	Continued From page 7 on a toileting program, and had an indwelling catheter placed. The following concerns were identified: a. Observation on 1/7/25 at 9:21 AM showed the resident was in his/her room and a catheter drainage bag was hanging on the side of the resident's trash can. b. Review of a hospital discharge note dated 6/13/24 showed the resident was discharged from the hospital to the facility following antibiotic therapy for 21 days. Further review showed "... [S/he] will continue with Foley catheter secondary to urine incontinence and recurrent infection..." c. Review of the physician orders showed no evidence of an appropriate diagnosis for the placement of a foley catheter. d. Interview with the DON on 1/8/25 at 4:16 PM revealed the resident previously had wounds on his/her legs and the catheter was placed to prevent infections in the legs. She revealed the facility had not attempted an external catheter or bladder retraining and she was aware the resident did not have an appropriate diagnosis for catheter placement. 2. Review of a facility policy titled "Bowel & Bladder Training" last revised on 8/15/18 showed "...All residents who are admitted to [the facility] will be evaluated for Bowel and Bladder training....The functions of the bowel and bladder conditions of each resident will be reassessed on a quarterly basis in conjunction with the care plan and MDS conferences, to assure the monitoring of these conditions and to enable prompt treatment if a problem should occur in bowel and bladder function...Residents will not qualify for Bowel or Bladder retraining if they have the following conditions: Multiple Sclerosis, Quadriplegia, neurogenic bladder, severe benign	F 690	readmitted with an indwelling catheter in place. If a resident fails scheduled bladder training, management and nursing will consult with primary care physicians for an assessment for an appropriate treatment and diagnosis. "Bowel and Bladder Training" facility policy will be updated to comply with regulation. B) All staff and physicians will receive education on appropriate diagnosis, usage and prompt discontinuation of indwelling catheters. Education will be including facility policy, "Bowel and Bladder Training." C) Quality monitoring on the use of indwelling catheter with appropriate diagnosis, reasoning, and discontinuing as soon as medically appropriate will be done by the Bowel and Bladder Nurse with each admission of a resident with an indwelling catheter or any insertion of an indwelling catheter using the quality improvement monitoring tool until substantial compliance has been met. D) Staff will receive immediate in-service and corrective action will be taken for any usage of an indwelling catheter for prolonged amount of time is found to be out of compliance. E) Resultes will be reported quarterly as part of the facility's quality assurance program by the Bowel and Bladder Nurse.	

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F 690	Continued From page 8 prostatic hypertrophy, comatose, Alzheimer's disease, combative and uncooperative to retraining, and if the resident is unable to cooperate due to being cognitively impaired..."	F 690		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		1/30/25

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F 758	Continued From page 9 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure target symptoms were identified and monitored for 6 of 6 sample residents (#2, #9, #36, #44, #45, #47) and failed to ensure PRN orders for psychotropic medications were limited to 14 days for 1 of 6 sample residents (#44) reviewed for unnecessary psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 12/10/24 showed resident #44 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment and diagnoses which included Alzheimers/dementia with agitation and depression. The MDS showed the resident had a mood score of 0, which indicated no signs or symptoms of depression, and the resident exhibited behaviors such as verbal behavior directed at others and wandering. Further review showed the resident received antipsychotic medication and antidepressent medication during	F 758	A) Facility will ensure that target symptoms are identified and monitored for residents #2, #36, #44, #45, and #47, all current and future residents prescribed psychotropic medication. The Behavior Committee will work to identify the targeted symptoms for residents on psychotropic mediciations, and the targeted symptoms will be added to the order for medical staff's knowledge. Monitoring targeted symptoms will be completed once a day in the medical recored by nursing staff and as needed when target symptoms or other symptoms occur. PRN lorazepam order for resident #45 has been evaluated by the primary care phyysician and discontinued. Resident #44 does not have an order for lorazepam, PRN or scheduled on his medical record to address. Facility will ensure PRN orders for psychotropic	

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F 758	Continued From page 10 the look-back period. Review of the physician orders showed the resident received olanzapine (antipsychotic) 7.5 milligrams (mg) by mouth twice a day, sertraline (antidepressant) 50 mg by mouth every day, and lorazepam (antipsychotic) 0.5 mg by mouth every day, PRN. The following concerns were identified: a. Review of the medical record showed no evidence the facility had identified or was monitoring medication specific target symptoms related to the psychotropic medications. b. Review of the physician's progress notes dated 10/23/24 showed the physician re-ordered the use of lorazepam 0.5 mg by mouth daily as needed, however there was no indication of a stop date. 2. Review of the quarterly MDS assessment dated 12/3/24 showed resident #36 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimers/dementia, anxiety and depression. The MDS showed the resident had a mood score of 0, which indicated no signs or symptoms of depression, and exhibited behaviors of inattention, disorganized thinking, physical behavior directed toward others, rejection of care, and wandering. Further review showed the resident received antipsychotic medication and antidepressent medication during the look-back period. Review of the physician orders showed the resident received lorazepam (antidepressant) 0.5 mg by mouth three times a day, quetiapine (antipsychotic) 150mg by mouth twice a day, and quetiapine (antipsychotic) 75mg by mouth at every lunch. The following concerns were identified: a. Review of the medical record showed no evidence the facility had identified or was	F 758	medications are limited to an initial 14 days and follow regulation when necessary for extension past the initial 14 days. If a PRN psychotropic medication will have an end date that is assocaited with that time frame documented by the primary care physician. "Antipsychotic Medication Use/PRN Psychotropic/Antipsychotic Order Procedure" facility policy will be updated to comply with regulations. B) All nurses, managers and physicians will receive education on the appropriate monitoring and documentation of target symptoms for residents prescribed a psychotropic medication and the necessary documentation for establishing a time frame of PRN psychotropic medications including an end date. Education will include facility policy "Antipsychotic Medication Use/PRN Psychotropic/Antipsychotic Order Procedure." C) Quality monitoring on the monitoring of target symptoms for residents prescribed psychotropic medications will be done weekly by the Director of Nursing using the quality improvement tool until substantial compliance has been met. Quality monitoring on the monitoring of PRN psychotropic orders compliance to defined time frame will be done weekly by MDS Coordinator using the quality improvement monitoring tool until substantial compliance has been met. D) Staff will receive immediate in-service and correction action will be taken for any targeted symptoms monitoring and PRN psychotropic medications order end date	

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(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 758	Continued From page 11 monitoring medication specific target symptoms related to the psychotropic medications. 3. Review of the quarterly MDS assessment dated 12/10/24 showed resident #45 had a BIMS score of 2 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimer's dementia, anxiety, and agitation due to dementia. The MDS showed the resident had a mood score of 0, which indicated no signs or symptoms of depression, and the resident exhibited behaviors such as verbal behavior directed at others and wandering. Further review showed the resident received antipsychotic medication and antidepressant medication during the look-back period. Review of the physician orders showed the resident received sertraline (antidepressant) 50 mg by mouth daily and lorazepam (antianxiety) .5mg by mouth every day as needed (PRN) for agitation-sedation. The following concerns were identified: a. Review of the medical record showed no evidence the facility had identified or was monitoring medication specific target symptoms related to the psychotropic medications. 4. Review of the quarterly MDS assessment dated 10/8/24 showed resident #47 had a BIMS score of 7 out of 15, which indicated severe cognitive impairment, and diagnoses which included Alzheimers/dementia, anxiety and depression. The MDS showed the resident had a mood score of 1, which indicated minimal signs or symptoms of depression, and exhibited behaviors of inattention, delusions, verbal behavior symptoms directed toward others, rejection of care, and wandering. Further review showed the resident received antipsychotic	F 758	is found to be out of compliance. E) Results will be reported quarterly as part of the facility's quality assurance program by the Director of Nursing and MDS Coordinator.	

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 01/09/2025

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F 758	Continued From page 12	F 758		

medication and antidepressant medication during the look-back period. Review of the physician orders showed the resident received quetiapine (antipsychotic) 100 mg by mouth twice a day, lorazepam (antianxiety) 1 mg by mouth at noon and 1 mg by mouth at night. The following concerns were identified:

a. Review of the medical record showed no evidence the facility had identified or was monitoring medication specific target symptoms related to the psychotropic medications.

5. Review of the quarterly MDS assessment dated 11/5/2024 showed resident #9 had a BIMS score of 14 out of 15, which indicated intact cognition, and diagnoses which included anxiety disorder, depression and insomnia. Review of the physician orders for the resident showed an order for venlafaxine (antidepressant) 150 mg daily and trazodone (antidepressant) 50 mg daily. The following concerns were identified:

a. Review of the medical record showed no evidence the facility had identified or was monitoring medication specific target symptoms related to the psychotropic medications.

6. Review of the admission MDS assessment dated 12/1/24 showed resident #2 resident had short-term memory loss and diagnoses which included Alzheimer's dementia, anxiety disorder, and depression. Further review showed the resident didn't exhibit any behaviors during the look-back period. Review of the medication administration record showed the resident received fluoxetine (antidepressant) 20 mg daily, buspirone (antianxiety) 10 mg daily, lorazepam (antianxiety) 0.5 mg twice daily, and olanzapine (antipsychotic) 10 mg daily. The following concerns were identified:

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F 758	Continued From page 13 a. Review of the medical record showed no evidence the facility had identified or was monitoring medication specific target symptoms related to the psychotropic medications. 7. Interview with the DON on 1/8/25 at 4:31 PM confirmed the facility had not identified and did not monitor medication specific target symptoms for the psychotropic medications. 8. Review of the policy titled "Antipsychotic medication use/PRN psychotropic/ antipsychotic order procedure" last reviewed 5/1/23 showed "1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. 3. The attending physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of psychotropic medications...PRN orders for psychotropic drugs are limited to 14 days initially. PRN orders for anxiolytics and antipsychotics must be reviewed for appropriateness 14 days after initiation. Providers must document the rational [sic]/benefit for continuing this prn order in the clinical record and must also indicate when this order will be re-evaluated. 1. Stop dates will be put in when ordering PRN psychotropic. They will not exceed 14 days for initial order. If provider documents the continue [sic] need and extends the timeframe, order can be adjusted to fit the timeframe. Timeframe cannot be indefinite or lifetime, 2-12 months max. This can be repeated as deemed necessary..."	F 758		

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