

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER New Horizons Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Lane 12 Lovell, WY 82431	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35081</p> <p>Based on medical record review, resident representative and staff interview, and policy and procedure review, the facility failed to protect the residents' right to be free from physical abuse by a resident for 2 of 4 sample residents (#1, #3) reviewed for allegations of abuse. This failure resulted in actual harm to resident #1. The findings were:</p> <p>1. Review of an incident dated 8/4/24 showed resident #2 punched resident #1 in the mouth with his/her fist. Further review showed resident #1 had a small cut and mild swelling. The following concerns were identified:</p> <p>a. Interview with RN #1 on 8/28/24 at 10:32 AM revealed resident #1 was demonstrating sundowners and was moving and straightening chairs. The RN revealed 2 residents near resident #1 asked the resident to leave the chairs alone and when s/he didn't, resident #2 stood up and popped resident #1 in the mouth. Further interview revealed resident #1 received an exterior abrasion, was upset, and was shocked.</p> <p>b. Interview with CNA #1 on 8/28/24 at 10:52 AM confirmed resident #1 was moving furniture and resident #2 punched resident #1 on the right side of his/her face. The CNA revealed resident #1 had bleeding and swelling to his/her face and s/he was cursing. The CNA revealed the resident continued to hold his/her face after it happened. Further interview revealed resident #2 was kind of dangerous, attacked staff, was aggressive without provocation, and usually goes after resident #1.</p> <p>c. Interview with CNA #2 8/28/24 at 10:22 AM revealed she did not observe the altercation; however, after it occurred, she observed the resident bleeding from his/her upper lip and would hold his/her face after the incident occurred.</p> <p>2. Review of an incident dated 7/21/24 showed resident #3 walked up to resident #1, grabbed resident #1's face and resident #1 slapped resident #3 in the face. Review of Actions Taken to Prevent Incident in Future showed suggest scheduling Ativan twice per day for resident #3. The following concerns were identified:</p> <p>a. Interview with RN #1 on 8/28/24 at 10:32 PM revealed she did not witness the incident between the residents; however, the CNA reported both residents were shocked by the incident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>b. Interview with CNA #3 on 8/28/24 at 10:48 AM revealed she was the only CNA on shift at the time of the incident and multiple residents were getting riled up. Resident #1 was sitting at the table, Resident #3 hit resident #1 in the face then resident #1 hit resident #3 in the face. Further interview revealed both residents were surprised by the incident.</p> <p>3. Interview with the resident representative for resident #1 on 8/27/24 at 5:35 PM revealed he was unsure how the resident would have reacted to prior to current health state as the resident would not get into altercations; however, he revealed the resident would probably be surprised.</p> <p>4. Interview with the resident representative for resident #3 on 8/27/24 at 6:02 PM revealed prior to the resident's current health state the resident would have been shocked and fearful if a similar incident had occurred.</p> <p>5. Review of the policy titled Abuse Prevention Program last reviewed 5/1/23 showed .1. Protect our residents from abuse by anyone including, but not limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual .</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35081</p> <p>Based on resident representative and staff interview, grievance review, state survey agency incident database review, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 1 of 4 sample residents (#3) reviewed for allegations for abuse. The findings were:</p> <ol style="list-style-type: none"> 1. Interview with the resident representative for resident #3 on 8/27/24 at 6:02 PM revealed the resident's spouse reported a CNA had pushed the resident down onto a chair on 8/25/24; however, she did not think the facility believed the spouse. 2. Review of a Complaint/Grievance form dated 8/25/24 showed [Spouse of resident #3] said CNA pushed [resident] down to sit in chair. 2. Review of the state survey agency incident database showed no evidence an allegation of abuse was reported for resident #3 on or after 8/25/24. 3. Interview with CNA #4 on 8/27/24 at 6:21 PM revealed she was providing 1 to 1 care for resident #3 on 8/25/24. Further interview revealed the DON arrived at the facility and sent the CNA home due to an allegation of abuse; however, after the DON watched the camera footage, she was told there was no evidence she abused the resident. 4. Interview with the DON on 8/28/24 at 11:22 AM confirmed the spouse of resident #3 reported a staff member had pushed the resident down into a chair roughly; however, the spouse was unable to see if the CNA did anything. The DON revealed the CNA was sent home and an investigation was initiated. Further interview confirmed the allegation was not reported to the state survey agency. 5. Review of the policy titled Abuse Prevention Program last revised on 5/1/23 showed .7. Investigate and report any allegations of abuse within timeframes as required by federal requirements . 		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35081</p> <p>Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure care plans were developed and implemented for 2 of 4 sample residents (#1, #2) following resident to resident altercations. The findings were:</p> <ol style="list-style-type: none"> 1. Review of an incident dated 8/4/24 showed resident #2 punched resident #1 in the mouth with his/her fist. Further review showed resident #1 had a small cut and mild swelling. Review of an incident dated 7/21/24 showed resident #3 walked up to resident #1, grabbed resident #1's face, and resident #1 slapped resident #3 in the face. The following concerns were identified: <ol style="list-style-type: none"> a. Review of the care plan for resident #1 last updated 7/1/24 showed no resident specific interventions related to altercations on 7/21/24 or 8/4/24. b. Review of the care plan for resident #2 last updated 7/20/24 showed no resident specific interventions related to aggression toward other residents or staff and no updated interventions related to the altercation on 8/4/24. 2. Interview with CNA #1 on 8/28/24 at 10:58 PM revealed resident #2 was kind of dangerous, attacked staff, was aggressive without provocation, and usually goes after resident #1. Further interview revealed staff implemented things they knew about residents because resident specific interventions were not on the care plans. 3. Interview with the MDS assessment coordinator on 8/28/24 at 11:22 PM revealed care plans should communicate interventions to staff and care plans have been a struggle. Further interview revealed the facility did not complete any type of analysis following incidents and confirmed care plans were not updated with all identified interventions. 4. Review of the policy titled Resident to Resident Altercations last revised on 6/2/20 showed .If two residents are involved in an altercation, staff will .e. Review the events with Nursing Supervisor and Director of Nursing, and possible measures to try to prevent additional incidents .g. Make any necessary changes in the care plan approaches to any or all of the involved individuals . 		