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	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Horizons Care Center	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50485 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 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.

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 [DATE] showed resident #33 had a BIMS score of 15 out 15, which indicated the resident 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 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 [DATE] 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 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 prostatic hypertrophy, comatose, Alzheimer's disease, combative and uncooperative to retraining, and if the resident is unable to cooperate due to being cognitively impaired .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50485 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 [DATE] 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 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 [DATE] 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 monitoring medication specific target symptoms related to the psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the quarterly MDS assessment dated [DATE] 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 [DATE] 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 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. 51658 5. Review of the quarterly MDS assessment dated [DATE] 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. 35081 6. Review of the admission MDS assessment dated [DATE] 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: 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. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 .