DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536030	A. BUILDING 01 - NEW HORIZONS CARE CE B. WING	01/08/2013

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
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinkled two story building of Type II (111) construction built in 1991. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility has a capacity of 85 certified Medicare and Medicaid beds with a census of 79. The facility meets the Life Safety Code standard based on the acceptance of a plan of correction and a Fire Safety and Evaluation System (FSES). Tag K-017 can be obviated by the Fire Safety and Evaluation System (FSES). If the facility agrees to the conditions of the FSES they can write an "F" in the providers Plan of Correction column and in the Complete Date column to accept the FSES. If the facility wants to fix the deficiency they can fill in the Providers Plan of Correction column with the appropriate information and dates.	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically	K 017	"F"	

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

Rick Schroeder — LNHA — 1-30-13

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.

POC ACCEPTED W/ RICK SCHROEDER, LPN 2/4/13

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: X6GM21 Facility ID: WY0019 If continuation sheet Page 1 of 8

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K 017	Continued From page 1 permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor walls were continuous from the floor to the roof in 6 of 6 smoke compartments. The findings were: Observation on 1/8/13 between 8 AM and 12 PM revealed the first and second floor corridor walls terminated above the lay in ceiling tiles. The open space above the corridors and resident rooms were used as an air plenum for the ventilation system. On 1/8/13 the maintenance director confirmed the ventilation system was not ducted and the open plenum was used to transfer air. This deficiency can be obviated by the Fire Safety and Evaluation System (FSES). If the facility agrees to the conditions of the FSES they can write an "F" in the providers Plan of Correction column and in the Complete Date column to accept the FSES. If the facility wants to fix the deficiency, they can fill in the Providers Plan of Correction column with the appropriate information and dates.	K 017	"F"	

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation of resident room #305 on 1/8/13 at 10:29 AM showed the door was not able to be fully latched into the door frame, with three attempts. At the time of the observation the maintenance director could not explain why aforementioned door had not been noticed and repaired during the quarterly inspections.	K 018	A) To insure the safety of residents and staff doors will be provided with suitable means of keeping the door closed. B) The door will be repaired to latch into the frame. C) Inspection of the latching hardware will be conducted quarterly and documented on the preventative maintenance checklist. D) This checklist will be monitored by the maintenance director. E) The results of this checklist will be reported to the quality committee quarterly.	2/24/13
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 026 SS=E	Continued From page 3 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 4 smoke barrier walls was smoke resistant. The findings were: 1. Observation on 1/8/13 at 8:59 AM showed the first floor smoke barrier wall above the server room had a 2 inch by 4 inch unsealed conduit penetration. At the time of the observation the maintenance director could not explain why the aforementioned penetration had not been noticed and repaired during the quarterly safety inspections. 2. Observation on 1/8/13 at 9:05 AM showed the first floor smoke barrier wall above the East alcove was not complete from the floor to ceiling above. The wall was missing the top 8 inches of sheetrock for a length of 10 feet. At the time of the observation the maintenance director could not explain why the aforementioned missing wall had not been noticed and repaired during the	K 026	A) Fire and smoke resistance will be maintained for safety of our residents. B) Wall penetrations will be sealed with 3M cp-25 fire barrier sealant. 5/8 sheetrock will be added to complete the missing wall. C) A visual inspection of the smoke barrier will be conducted quarterly and documented on the preventative maintenance checklist. D) This checklist will be monitored by the maintenance director. E) Results of the checklist will be reported to the quality committee quarterly.	2/24/13

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K 025	Continued From page 4 quarterly safety inspections.	K 025		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 10.2.9.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the emergency generator was equipped with a remote emergency stop button. The findings were: Observation of the emergency corridor lights showed they were supplied with power from the emergency generator. Observation of the generator on 1/8/13 at 11:40 AM showed it was located inside the building near the main electrical room. Further observation showed the generator was not equipped with an emergency stop button. At the time of the observation the maintenance director reported he was unaware an emergency stop button was required. Reference, NFPA 101, 2000 Edition, 10.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 3-5.5.6 All Level 1 and Level 2 installations shall have a remote manual stop station of a type similar to the break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building.	K 046	A) To insure the safety of residents and staff Generator equipment will be maintained according to NFPA 101. B) The Generator will be equipped with an emergency stop button. C) The emergency stop button will be inspected for proper operation monthly. D) The operation of the emergency stop button will be recorded on the generator run sheet.	02/24/13
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050	A) To insure the safety of residents and staff fire drills will be at different times of day.	02/24/13

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K 060	Continued From page 5 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were held at varying times on 1 of 3 shifts. The findings were: Review of the fire drill records showed the second shift occurred between 3 PM and 11 PM. Further review showed the drill performed on the second shift over the past year all occurred between 3 PM and 4:40 PM. On 1/8/13 at 12:05 PM the maintenance director reported he was unaware the drills were required to be at varying times throughout the shift.	K 060	B) The fire drills will be performed at least two hours apart on the different shifts. C) The fire drills will be monitored on the fire drill calendar for the three shifts. D) The fire drill calendar will be monitored by the maintenance director.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 062	A) To insure the safety of residents and staff the fire alarm system will be tested according to NFPA 101.	2/24/13

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K 062	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 7 fire alarm system components was tested. Findings were: Review of the fire alarm system testing records showed the system was last tested on 6/24/12. Further review showed the semi-annual load voltage test had not been performed on the batteries in the fire alarm control panel in the past six months. On 1/8/13 at 12:05 PM the maintenance director reported he was unaware of the aforementioned test. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test.....annually (Replace batteries every 4 years.) 2. Discharge Test .....annually (30 minutes) 3. Load Voltage Test.....semi-annually	K 062	B) The fire alarm control panel battery load test will be done semi-annually. C) The fire alarm control panel load test will be added to the preventative maintenance checklist. D) This checklist will be monitored by the maintenance director. E) The results will be reported to the quality committee quarterly.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 6	K 147		

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K 147	Continued From page 7 smoke compartments. The findings were: Observation of the electrical system on 1/8/13 between 9 AM and 10:30 AM showed the television set in resident room #222 and #328 were plugged into a 3-way electrical adapter. On 1/8/13 at 9:15 AM the maintenance director could not explain why the aforementioned electrical adapters had not been noticed and removed during the quarterly safety inspections. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	A) Electrical equipment will be maintained according to NFPA 70 for the safety of residents and staff. B) The three way adapters will be removed and all rooms will be inspected monthly. C) Rooms will be inspected monthly and added to a preventative maintenance checklist. D) The preventative maintenance checklist will be reviewed by the maintenance director. E) The results of this checklist will be reported to the quality committee quarterly.	2/24/13