PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____	03/06/2014

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 Stories: 2 Construction type: Type II(111) Constructed: 1992 K0180: Fully Sprinkled Certified Beds: 85 Census: 77	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to separate additions from existing non-conforming construction with 2 hour fire resistance rated construction. Findings include: On 3/5/14 review of the coonstruction plans did not show a 2 hour fire resistance rated (FRR)separation between the hospital and the nursing home addition. The cross corridor doors that separated the structures were 45 minute rated doors normally used in a 1 hour FRR separation. Ninety (90) minute rated doors are normally provided in 2 hour FRR construction. The Administrator indicated that that the buildings	K 011	(A) Fire barriers will be maintained for the safety of staff and residents. (B) Construction of a fire barrier with a two hour fire resistance rating. (C) A time extension request will be submitted for design and plan submittal for state review. We expect design completed by 4/30/14. State review by 5/30/14. Construction and final inspection by 7/30/14. (D) Fire barrier will be inspected as required by NFPA guidelines.	7/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rick Schrock | TITLE: UNHA | (X6) DATE: 3-19-14

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.

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K 011	Continued From page 1 should be considered separate with a deficiency in the 2 hour FRR separation between the two structures. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to maintain separation as required increases the risk of death or injury due to fire. The deficiency affected one of one additions. Ref: 2000 NFPA 101 Section 19.1.1.4.1	K 011		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier doors as required. Findings include: On 3/5/14, a door in the smoke barrier on the first floor infection control office was found to not be	K 027	(A) To insure the safety of our staff and residents a smoke barrier will be maintained according to NFPA 101. (B) Self closing device will be installed on the smoke barrier door on the first floor infection control office. (C) The smoke barrier will be on the quarterly preventative maintenance checklist. (D) Checklist will be completed by the maintenance department and inspected by the maintenance director.	4/12/14

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K 027	Continued From page 2 self-closing as required. There were holes in the door frame and the door that indicated that the closer had been present in the past. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to maintain smoke barrier doors as required increases the risk of death or injury due to fire. The deficiency affected one of numerous smoke barrier doors. Ref: 2000 NFPA 101 Section 19.3.7.6	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas as required. Findings include:	K 029	(A) To insure the safety of our staff and residents a smoke barrier will be maintained according to NFPA 101. (B) The pod 5 dinning room will be cleaned out of all the excess equipment and care center staff will be made aware that its not to be used as storage. (C) The inspection of storage in a non-storage room will be added to the monthly preventative maintenance checklist.	4/12/14

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K 029	Continued From page 3 On 3/5/14 the door to POD 5 dining room was not self-closing as required. The room was estimated to be 200 sf (10 ft x 20 ft) was found to be storing mattresses, chairs and wheel chairs. The door closer on the subject door could be opened to a position that did not release upon loss of power or activation of smoke detectors rated for hold open service. Rooms exceeding 50 sf with a combustible load are considered hazardous areas. Doors to hazardous areas are required to self closing. If held open, they are required to close upon loss of power or activation of smoke detectors rated for door release service. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to maintain doors in hazardous areas as required increases the risk of death or injury due to fire. The deficiency affected one of six smoke compartments. Ref: 2000 NFPA 101 Section 19.3.2.1, 7.2.1.8.2, 1999 NFPA 72 Section 2-10.6	K 029	(D) The monthly preventative maintenance checklist will be monitored by the maintenance director.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by:	K 038		

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K 038	Continued From page 4 Based on observation and interview, the facility failed to maintain the means of egress to be available at all times. Findings include: On 3/5/14 the doors on the second floor of stairwells 3232 and 3214 were found to be secured with a magnetic lock that required operatio of a keypad to release. Doors in the means of egress are not permitted to be equipped with a lock or latch that requires special knowledge or effort to operate. The device is also required to be operable under all lighting conditions. The keypad requires special knowledge and effort and is not operable under all lighting conditions. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to maintain the means of egress to be available at all times increases the risk of death or injury due to fire. The deficiency affected two of ten stairwell doors that served the first and second floors. Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4	K 038	(A) Egress doors will be maintained according to NFPA 101 for the safety of our residents and staff. (B) The key pad locks on the stairwell 3232 and 3214 will be removed and replaced with a delayed egress lock. (C) The delayed egress latch will be inspected for proper operation monthly. (D) The operation of the delayed egress latch will be inspected monthly on the preventative maintenance checklist.	4/12/14
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire dampers as required. Findings include: On 3/5/15 four fire dampers were not maintained as required. Records review indicated that there were four dampers that were not accessible for the 4 year maintenance procedure performed on 3/7/12. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to maintain dampers as required increases the risk of death or injury due to fire. The deficiency affected four of an estimated forty (40) dampers in the building. Ref: 2000 NFPA 101 Section 19.5.2.1, 9.2, 9.2.1; 1999 NFPA 90A Section 3-4.7	K 067	(A) Fire dampers will be maintained for the safety of residents and staff. (B) Access will be made to the four fire dampers. Dampers will be maintained and records kept according to NFPA 101 (C) Fire dampers will be inspected and records of maintenance and inspection completed every four years. (D) Results of the inspection will be monitored by the Maintenance Director.	4/12/14
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain penetrations to smoke barriers	K 104		

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K 104	Continued From page 6 as required. Findings include: On 3/5/14 an unsealed gap in the smoke barrier sheet rock was found above a 6 inch metal duct on the second floor at the nurse ' s station in the special care unit. Penetration of the smoke barrier is required to be sealed with a material that is capable of maintaining the smoke resistance of the smoke barrier. The Maintenance Director acknowledged the finding when the deficiency was identified. Failure to seal smoke barriers as required increases the risk of death or injury due to fire. The deficiency affected one of six smoke compartments. Ref: 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1	K 104	(A) Fire and smoke barriers will be maintained for safety of staff and residents. (B) Wall penetrations will be sealed with 3M intumescent fire barrier sealant cp-25 wpt. (C) A visual inspection of fire separation walls will be conducted quarterly and documented on the preventative maintenance Checklist. (D) These checklists will be monitored by the Maintenance Director.	4/12/14