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

PRINTED: 04/23/2015
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
	535030	A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____	04/07/2015

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 sprinklered, 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 71. 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 K017 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 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 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	K 011		

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

Nick Schroeder — CEO/LNHA — 4-27-15

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.

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: DIBT21 — Facility ID: WY0019 — If continuation sheet Page 1 of 5

MAY 01 2015
Healthcare Licensing and Surveys

POC Accepted VIA Phone Call with the Administrator ~~of~~ Rick Schroeder on 5/14/2015 at 9:12 AM. LSC 34354

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

PRINTED: 04/23/2015
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
	535030	A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____	04/07/2015

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 011	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate additions from existing non-conforming construction with 2 hour fire resistance rated construction. The finding were: Observation of the Cross Corridor Doors that separated the structures on 04/07/2015 at 12:45 PM revealed the doors were 45 minute rated doors, and not the required 90 minute doors for a 2 hour FRR construction. The Maintenance Director acknowledged the finding and stated they planned on correcting this deficiency during the new construction project taking place in the hospital. Ref: 2000 NFPA 101, Section 19.1.1.4.1	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 rating. C) Plans have been submitted to the state for approval. D) Fire barriers will be inspected as required by NFPA guidelines.	6/5/15
K 017 SS=D	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 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	K 017		

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

PRINTED: 04/23/2015
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
	535030	A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____	04/07/2015

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 017	Continued From page 2 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 04/07/15 between 12:40 PM and 2:45 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. 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 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. Ref: 2000 NFPA 101, Section 19.3.6.2.1	K 017	F	F
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	K 029		

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

PRINTED: 04/23/2015
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
	535030	A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____	04/07/2015

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 029	Continued From page 3 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 staff interview, the facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 2 of 6 smoke compartments. The findings were: 1. Observation of Room 2131 on 04/07/15 at 12:52 PM revealed the door was provided with a self-closing device, but when activated the door would not latch into the frame. At the time of the observation, the Facility Maintenance Manager acknowledged the door would not latch into the frame to resist the passage of smoke. 2. Observation of Room 2108 on 04/07/15 at 1:05 PM revealed the door was provided with a self-closing device, but when activated the door would not latch into the frame. At the time of the observation, the Facility Maintenance Manager acknowledged the door would not latch into the frame to resist the passage of smoke. 3. Observation of Room 3215 on 04/07/15 at 1:35 PM revealed the door was provided with a self-closing device, but when activated the door would not latch into the frame. At the time of the observation, the Facility Maintenance Manager acknowledged the door would not latch into the	K 029	A) To ensure the safety of staff and residents doors will be provided with suitable means of keeping the doors closed. B) The doors will be repaired to latch into the frame. C) Inspection of the closing and 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 the checklist will be reported to the quality committee quarterly.	6/5/15

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

PRINTED: 04/23/2015
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 CENTER B. WING _____	04/07/2015

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 029	Continued From page 4 frame to resist the passage of smoke. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation, documentation review, and interview, the facility failed to ensure that combustible decorations were flame-retardant in 1 of 6 smoke compartments. The findings were: Observation of the POD 3 Dining Area on 04/07/15 at 12:46 PM revealed a curtain without flame-retardant information attached. Subsequent documentation review could not locate the curtain ' s flame-retardant information. At the time of the observation, the Facility Maintenance Manager acknowledged the missing information. Ref: 2000 NFPA 101, Section 19.7.5.4	K 073	A) To ensure the safety of staff and residents curtains will be maintained according to NFPA 101 Life Safety Code. B) Curtains and wall hangings will be inspected quarterly by the activities department. C) Activities will request for maintenance to fire treat curtains and wall hangings, activities will label treated curtains with the date they were treated. D) Activities will send a quarterly report to the maintenance director. E) Maintenance director will review the quarterly report.	6/5/15