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 CI B. WING _____	10/05/2009

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 (NFPA). 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 addressable fire alarm system. The facility has a capacity of 85 certified Medicare and Medicaid beds. 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 and "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	POC MODIFIED & ACCEPTED W/ RICK SCHABRON, CDO, ON 11/04/09.	
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 permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces	K 017	"F"	"F"

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

Mary Beer RN — Administrator — 10-23-2009

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.

RECEIVED
Wyoming Dept of Health
OCT 26 2009
Office of Healthcare Licensing and Surveys

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K 017	Continued From page 1 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: 1. Observation on 10/05/09 between 9:30 AM and 12:30 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. 2. Interview with the maintenance director on 10/05/09 at 12:30 PM 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 and "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 017		

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K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 were smoke resistant. The findings were: Observation on 10/05/09 at 12:54 PM showed the second floor smoke barrier wall above the east double doors had one unsealed pipe penetrations. The penetration was located above the sprinkler pipe and was ½ inch in diameter. At the time of observation the maintenance director reported barrier walls were inspected quarterly.	K 025	A) Fire and smoke resistance will be maintained for the safety of residents. B) Wall penetrations will be sealed with 3M intumescent fire barrier sealent cp-25 wpt. C) A visual inpection of fire separation walls will be conducted quarterly and documented on the preventative maintenance checklist. D) These checklists will be monitored by the Facility Services Director for completion. E) Results of these checklists will be reported at quarterly Quality Assurance meetings.	11/20/09
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 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	K 050	A) Fire drills will be conducted at least quarterly on each shift for the safety of residents and staff. B) Fire drill will be held at varing times under various conditions to insure staff is familiar with established procedures. C) Dates, times, and conditions will be noted in the Fire Drill Log and Preventative maintenance checklist. D) This log and Preventative maintenance checklist will be reviewed by the	11/20/09

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K 050	Continued From page 3 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 2 of 3 shifts. The findings were: Review of the fire drill testing records documented the first shift occurred between 7 AM and 3 PM and the second shift occurred between 3 PM and 11 PM. Further review showed the drills conducted on the first shift over the past year all occurred between 9:28 AM and 10:20 AM. The records also showed the drills conducted on the second shift over the past year all occurred between 3 PM and 3:15 PM. On 10/05/09 at 1:40 PM the maintenance director confirmed the aforementioned drill times. He also reported that he was unaware the drills were required to occur throughout the shift.	K 050	Facility Services Director. E) Results of these checklists will be reported at quarterly Quality Assurance meetings.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinklers were unobstructed in 2 of 6 smoke compartments. The findings were: Observation on 10/05/09 between 9 AM and 1 PM	K 062	A) The automatic sprinkler system will be maintained in reliable operating condition for the safety of residents and staff. B) The sprinklers in the laundry area will be lowered so lights will not obstruct the sprinkler operation, the light in storeroom #2107 will be re-located to allow for the sprinkler to be lowered to provide the necessary clearance. C) A visual inspection of the automatic sprinkler system will be inspected quarterly and documented on the pre-ventative maintenance checklist. D) This preventative maintenance check-list will be monitored by the Facility Services Director.	11/20/09

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K 062	Continued From page 4 showed the sprinkler head in storeroom #2107 A and the two heads above the clothes washing machines in the laundry were obstructed by ceiling mounted fluorescent lights. The sprinklers were located less than 12 inches away from the lights and the deflectors were installed above the bottom of the lights. At 9:18 AM the maintenance director reported the sprinklers in the aforementioned areas were not routinely inspected.	K 062	E) Results of these checklists will be reported at the quarterly Quality Assurance meetings.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure oxygen cylinders were restrained in 1 of 6 smoke compartments. The findings were: Observation on 10/05/09 at 10:20 AM showed an " E " sized oxygen cylinder was stored in resident room #218 and not restrained. At the time of observation the maintenance director reported he was aware the cylinder was required to be	K 076	A) Medical gases will be stored in accordance with NFPA 99 standard for Healthcare Facilities for the safety of Residents and Staff. B) The E sized oxygen cylinder in resident room #218 will be relocated to an approved storage area and secured. C) The New Horizons Care Center Director of Nursing will provide and educate staff with education sessions for the staff on the proper storage and medical gases. D)The New Horizons Care Center staff will round weekly to insure cylinders are stored properly with reports of non-compliance forwarded to the Facility Services Director. E) The New Horizons Care Center Director of Nursing will report compliance monitoring to the Quality Assurance Committee.	10/30/09

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K 076	Continued From page 5 restrained. At 2:15 PM the DON (director of nursing) reported all staff members were aware oxygen cylinders are required to be restrained.	K 076		
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure compressed flammable liquids were stored in approved containers in 1 of 6 smoke compartments. The findings were: Observation on 10/05/09 at 10:36 AM showed the resident in room #204 had wood working crafts and supplies in his room. Further review showed four 18 ounce cans of compressed clear spray lacquer were being stored in his cabinet. At the time of observation the maintenance director reported he was unaware the resident was storing the aforementioned products. When asked he reported the room was inspected monthly, but the cabinet was not checked. He further reported that he had not asked the resident if he was storing flammable products.	K 135	A) To insure the safety of residents and staff hazardous material will not be stored in unapproved areas. B) The clear spray lacquer and other flammables will be removed from the residents cabinet in room #204. C) The New Horizons Care Center Nursing will visually inspect the area monthly to insure flammable products are not stored in unapproved areas. D) A copy of these inspections will be forwarded to the Facility Services Director for review. E) The New Horizons Care Center Director of Nursing will report quarterly to the Quality Improvement Committee.	10/30/09
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	A) Electrical equipment will be main-	10/30/09

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K 147 SS=D	Continued From page 6 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 electrical receptacle in wet locations were GFCI (ground fault circuit interrupter) protected. They also failed to ensure permanent wiring was not replaced by temporary wiring in 2 of 6 smoke compartments. The findings were: 1. Observation on 10/05/09 at 9:54 AM showed electrical receptacle behind the sink in the first floor activities room was located less than 6 feet from a water source. The receptacle was not equipped with a GFCI receptacle. One of the three receptacles on the same wall was supplied with a GFCI protection. The GFCI receptacle was tripped to see if the receptacle in question was protected, but it was not. At the time of observation the maintenance staff reported they thought the GFCI receptacle protected all three receptacles on the wall, but it was not tested. 2. Observation on 10/05/09 at 10:54 AM showed the computer in the business office was plugged into a surge protector which was, itself, plugged into a multi-plug extension cord. At the time of observation the maintenance director reported the electrical system was inspected monthly. He further reported that this issue had been noted, but they thought it was an approved application.	K 147	according to NFPA 70, National Electrical Code to insure the safety of residents and staff. B) The electrical outlet in the Activites room will be replaced with and approved GFCI receptacle. C) Electrical outlet inspections have been added to the quarterly Preventative Maintenance schedule. D) Preventative Maintenance Checklist will be reviewed quarterly by the Facility Services Director. E) Results of these checklists will be reported to the Quality Assurance Committee. F) EXTENSION CORDS IN BUSINESS OFFICE WERE REMOVED. QUARTERLY INSPECTIONS OF THE ELECTRICAL SYSTEM TO ENSURE FACILITY WISE COMPLIANCE.	