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

PRINTED: 06/30/2016
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 _____	06/02/2016

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 42CFR 483.70(2) 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 a addressable fire alarm system. The facility has a capacity of 85 certified Medicare and Medicaid beds with a census of 71.	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Observation and interview revealed that the facility failed to provide an approved, readily visible sign on an exit doorway. 1. Observation on 6/02/16 at 10:23 AM of the second floor south balcony and assembly area, which contained furniture and seating, revealed that the exit door into the interior corridor was not identified as an exit. Interview with facility maintenance personal revealed that they were unaware that the door required to be identified as an exit.	K 022	(1-A) Access to exits will be marked by approved signs, for the safety of staff and residents. (B) An exit light will be installed on the second floor south balcony. (C) Inspection of the exit will be added to the preventative maintenance checklist. (D) This checklist will be monitored by the Facilities Director.	7/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Schaal | TITLE: LNHA | (X6) DATE: 06/17/2016

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
JUL 18 2016
Healthcare Licensing and Surveys

I have informed Vickie Craft that the POC has been accepted.
7-25-2016

PRINTED: 08/30/2016
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 _____	06/02/2016

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 022	Continued From page 1 2. Observations on 6/02/16 at 9:25 AM and 10:05 AM of rooms 3207 and 3257 respectively, revealed non-exiting doors with signs displayed reading "NOT AN EXIT". Interview with facility maintenance personal revealed that they were unaware of the required language on signs for non-exiting doors.	K 022	(2-A) Access to exits will be marked by approved signs, for the safety of staff and residents. (B) Not an exit signs will be changed to read no exit. (C) Staff will be educated on the correct wording according to NFPA 101. (D) Maintenance personnel will inspect exit signs on a monthly basis.	
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: Observation and interview revealed that the facility failed to provide a means of egress free of all obstructions or impediments. Observation on 6/02/16 at 10:55 AM of the identified exits into the ground level north end porch revealed that furniture had been stored in the means of egress impeding access to the public right-of-way in case of an emergency. Interview with the facility maintenance personnel identified that contractors working on site had moved furniture to accommodate storage of construction materials. Ref. 7.1.10.1	K 038	(K 038/ 1-A) For the safety of staff and residents. Exit access will be arranged so exits are accessible at all times. (B) Outside contractors policy will be rewritten to to add that Exit access will be arranged so exits are accessible at all times. (C) Staff and contractors will be educated on exit accessibility. (D) Maintenance will make daily rounds to inspect all exits.	7/10/16
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved	K 052		6/10/16

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

PRINTED: 06/30/2016
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 _____	06/02/2016

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 052	Continued From page 2 maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. This STANDARD is not met as evidenced by: Based on observation, interview and documentation review the facility failed to provide written record of all required testing for the fire alarm system. 1. Review of the facility documentation on 6/01/16 starting at 3:22 PM revealed that no record of the fire alarm systems yearly UL listing was available. Interview with the facility maintenance personnel revealed that the testing by the fire alarm company had been completed but they did not receive the UL listing record. 2. Review of the facility documentation on 6/01/16 starting at 3:22 PM revealed that the last Semi-Annual Battery Load Test performed by the facility was done over 6 months prior to the survey. Interview with the facility maintenance personnel revealed that the facility has a scheduled test in the coming month. 3. Review of the facility documentation on 6/01/16 starting at 3:22 PM revealed that no record of the smoke detector smoke entrance test was available. Interview with the facility maintenance personnel revealed that testing had been completed but records had not been received by the facility.	K 052	(K 052/1) Our alarms are monitored by our city dispatch. Which does not require UL listing. (052/2A) For the safety of staff and residents semi-annual battery load test will be completed. (B) The test will be completed by API System integrators. (C) The tests are added to the annual preventative maintenance checklist. (D) The preventative maintenance checklist will be monitored by the facility director. (K 052/3A) For the safety of our staff and residents the smoke detector inspection will be completed. (B) The test will be completed by API System integrators. (C) The tests are added to the annual preventative maintenance checklist. (D) The preventative maintenance checklist will be monitored by the facility director.	
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,	K 062		6/7/16

PRINTED: 06/30/2016
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 _____	06/02/2016

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 062	Continued From page 3 9.7.5 This STANDARD is not met as evidenced by: Observation and interview revealed that the facility failed to perform all necessary inspection and testing on the automatic sprinkler system. Observation 6/01/16 at 3:52 PM of the fire riser system located within the emergency generator room revealed that the fire riser system had pressure gauges that had been last calibrated over 5 years prior to the survey. Interview with the facility maintenance staff revealed that the pressure gauges had been overlooked in the latest inspection.	K 062	(K 062/1-A) For the safety of our staff and residents the pressure gauges will be replaced and calibrated. (B) Pressure gauges have been changed and been calibrated. (C) install dates have been put on the gauge. (D) Maintenance personnel will be responsible for inspection and recalibration.	
K 161 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2 (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) This STANDARD is not met as evidenced by: Observation and interview revealed that the facility failed to conform with the requirements of ASME/ANSI A17.3. Observation on 6/02/16 at 10:29 AM of the elevator equipment room revealed that it was being used to store equipment and maintenance items. Interview with the facility maintenance personnel revealed they were unaware that	K 161	(K 161/1-A) For the safety of our staff and residents the elevator equipment room will not be used for storage. (B) Items will be moved to an approved storage area. (C) Elevator equipment room will be added to the preventative maintenance inspection.	7/10/16

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

PRINTED: 08/30/2016
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 _____	08/02/2016

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 161	Continued From page 4 elevator equipment rooms could not be used for storage.	K 161	(D) Maintenance personnel will be responsible to check monthly.	