

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on June 25th, 2019. 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 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, two story building with a mechanical equipment penthouse of Type II(111) construction built in 1991. The building was equipped with a supervised automatic sprinkler system and an addressable fire alarm system. The facility had a capacity of 85 certified Medicare and Medicaid beds with a census of 69 residents.	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress could	K 211	A.)To ensure the safety of staff and residents, the curtain will be removed from the egress door in the activities room.	7/30/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/17/2019

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.

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 211	Continued From page 1 result in injury or death in the event of an emergency. The deficiency affected one (1) of three (3) smoke compartments on the first floor. The findings were: Observation on 06/25/19 at 12:10 PM revealed the activities room on the first floor had an egress door that led to the exterior. Further observation revealed that a curtain was hung over the egress door, which obstructed both visibility of, and access to, the doors releasing hardware. Decorations shall not obstruct access to, egress from, or visibility of an exit. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.1, 7.1.10.2	K 211	B.)All egress will be inspected and maintained so not to block visibility and access to the door releasing hardware and be in compliance with 2012 NFPA 101 Life Safety Code. C.)All means of egress will be maintained and inspected by maintenance personal and logged on monthly preventative maintenance logs. D.)Inspection sheets will be reviewed by the Facility Services Director and reported to the Quality Committee.		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing	K 321		7/30/19	

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 2 and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect hazardous areas could result in injury or death in the event of a fire. The deficiency affected one (1) of three (3) smoke compartments on the second floor. The findings were: Observation on 06/25/19 at 12:47 PM revealed the clean storage room located on the second floor in the staff hallway was being used to store combustible material, but the door was not equipped with an automatic door closer. Hazardous areas that are protected with an automatic extinguishing system shall have doors that are self-closing or automatic-closing.	K 321	A.)To ensure the safety of staff and residents. The clean room behind the nurses station on the second floor will have a door closer installed by maintenance personnel. B.)Doors in hazardous areas will be inspected and provided with a suitable means of keeping the doors closed. C.)All storage areas will have door hardware inspected yearly by a certified inspector. D.)Inspection sheets will be logged reviewed by the Facility Service Director and kept on file.		

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 3 Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.3	K 321			
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920			7/30/19

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NEW HORIZONS CARE CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 920	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly use power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly use power strips could result in injury or death. The deficiency affected two (2) of six (6) smoke compartments. The findings were: Observation on 06/25/19 at 11:34 AM revealed resident rooms 241, 239, and 234 had patient care related electrical equipment (PCREE) plugged into a power strip located next to the patient bed. Resident room 225 had PCREE located in the room with a power strip located in the patient care area. Resident rooms with patient care related electrical equipment in them shall not have a power strip. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency.	K 920	A.)To ensure the safety of staff and residents. Power strips and surge protectors will be removed from rooms 241, 239 and 234. B.)Patient care areas and the electrical systems will be inspected and maintained to comply with NFPA 70 National electric code and NFPA 2012 99 Health Care Facilities Code. C.)All patient care areas will be inspected monthly by maintenance personnel and recorded on our preventative maintenance inspection checklist. D.)Inspection sheets will be reviewed by the Facility Services Director and reported to the Quality Committee.		

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 06/25/19.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only.	E 015		8/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/19/2019

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.

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 015	Continued From page 1 The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide policies or procedures for subsistence needs for staff and patients. The findings were: Document review of the Emergency Preparedness Plan on 06/25/19 at 1:55 PM revealed the facility did not have policies or procedures addressing subsistence needs for staff and patients when they evacuate or shelter in place. Interview with the facility administrator revealed that policies are still being finalized that address this requirement.	E 015	North Big Horn Hospital District will develop and implement policies and procedures that will provide subsistence for staff and patients whether they are evacuated or sheltered in place. These policies and procedures will be drafted by the North Big Horn Hospital District's Hospital Preparedness Committee which includes staff members from the New Horizons Care Center, North Big Horn Hospital Clinic and North Big Horn Hospital. The North Big Horn Hospital District Hospital Preparedness Committee's chairman is responsible to develop and implement policies that will provide subsistence for staff and patients. These policies and procedures will be annexed into the Emergency Operations Plan of		

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 015	Continued From page 2	E 015	North Big Horn Hospital District and will be evaluated each year for effectiveness and sustainability. These policies and procedures will be integrated into the quality assurance system of North Big Horn Hospital. Once completed the policies and procedures will be added to the electronic policy and procedure repository and the North Big Horn Hospital Intranet and presented during annual staff education. The policy and procedures will be reviewed annually by the policy and procedure committee. Updates will be presented quarterly to the quality committee. There will be at least one annual unannounced mock disaster/emergency.		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the	E 018		8/26/19	

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 018	Continued From page 3 [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of	E 018			

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 018	Continued From page 4 assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide policies or procedures for the tracking of staff and patients. The findings were: Document review of the Emergency Preparedness Plan on 06/25/19 at 1:55 PM revealed the facility did not have policies or procedures addressing a system to track the location of on-duty staff and patients if relocated during an emergency. Interview with the facility administrator revealed that policies are still being finalized that address this requirement.	E 018	North Big Horn Hospital District will develop and implement a system to track the location of on-duty staff and sheltered patients in it's care during an emergency. The Tracking System will also track the staff and inpatients relocation during the emergency with documentation of the specific name and location of the receiving facility or other location. The North Big Horn Hospital District Hospital Preparedness Committee will be responsible to draft and distribute this Tracking System to staff members. The Hospital Preparedness Committee's chairman will be responsible to monitor the implementation, sustainability and evaluate the system annually. The final draft of the Tracking System will be integrated into the North Big Horn Hospital quality assurance program. This Tracking System policy and		

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 018	Continued From page 5	E 018	procedure will be annexed into the North Big Horn Hospital District' Emergency Operations Plan. Once completed the policies and procedures will be added to the electronic policy and procedure repository and the North Big Horn Hospital Intranet and presented during annual staff education. The policy and procedures will be reviewed annually by the policy and procedure committee. Updates will be presented quarterly to the quality committee. There will be at least one annual unannounced mock disaster/emergency.		
E 020 SS=F	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020		8/26/19	

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 020	Continued From page 6 *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCl or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide policies or procedures for evacuation of the facility. The findings were: Document review of the Emergency Preparedness Plan on 06/25/19 at 1:55 PM revealed the facility did not have policies or procedures addressing the safe evacuation of the	E 020	North Big Horn Hospital District will develop and implement a policy and procedure for the safe Evacuation and Primary/Alternate Communications for our facilities including North Big Horn Hospital, New Horizons Care Center and North Big Horn Hospital Clinic. These policies and procedures will include all departments within North Big Horn Hospital District including but not limited		

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

PRINTED: 07/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 020	Continued From page 7 facility. Interview with the facility administrator revealed that policies are still being finalized that address this requirement.	E 020	to: Occupation Therapy, Speech-Language Pathology, Physical Therapy and include staff responsibilities and communication with external sources of assistance. The North Big Horn Hospital District Hospital Preparedness Committee's chairman will be responsible to draft and distribute this Evacuation and Communication policy and procedure to staff members. The final draft of the Evacuation and Communications policy and procedures will be integrated into the North Big Horn Hospital quality assurance system. The Evacuation and Communication policy and procedure will be annexed into the North Big Horn Hospital District's Emergency Operation Plan. Once completed the policies and procedures will be added to the electronic policy and procedure repository and the North Big Horn Hospital Intranet and presented during annual staff education. The policy and procedures will be reviewed annually by the policy and procedure committee. Updates will be presented quarterly to the quality committee. There will be at least one annual unannounced mock disaster/emergency.		