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 _____	**05/16/2018**

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 A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on May 16th, 2018. 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 70 residents. .	K 000		
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 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	K 321		6/14/18

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

Electronically Signed | 06/06/2018

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 321	Continued From page 1 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 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 deficiencies affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/16/2018 at 9:34 AM revealed the Clean room in the hallway behind the nurses station on the first floor was being used to store a large amount of combustible material, but did not have an automatic door closer. Hazardous areas that are protected with an automatic extinguishing system shall have doors that are self-closing or automatic-closing. Interview with maintenance personnel at the time of the observation acknowledged the deficiency, and indicated he was aware of the requirement.	K 321	K321 (A) To ensure the safety of staff and residents doors in hazardous areas will be provided with a suitable means of keeping the doors closed. (B) The clean room behind the nurses station will have a door closer installed by maintenance personnel. (C) All storage areas will have door hardware and inspected yearly by a certified inspector. (D) Inspection sheets will be logged and reviewed by the facility maintenance director.	

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K 321	Continued From page 2 Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1 .	K 321		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to protect smoke compartment barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect smoke compartment barriers could result in injury or death by allowing the propogation of smoke or fire. The deficiencies affected one (1) of three (3) smoke compartments on the main floor. The findings were: Observation on 05/16/2018 at 11:45 AM revealed unprotected plumbing and electrical penetrations	K 372	(A)To ensure the safety of staff and residents all smoke barriers will be maintained in accordance with the 2012 NFPA 101 Life Safety Code. (B)The penetrations above the cross-corridor doors at the nurses station and the main floor lobby will be repaired and fire chalked by maintenance personnel. (C)All smoke compartments will be inspected quarterly by maintenance personnel and recorded on our preventative maintenance inspection	6/19/18

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K 372	Continued From page 3 above the cross-corridor doors next to the main floor nurses station. Observation also revealed sections of missing drywall at the smoke barrier and ceiling in the main floor lobby. Smoke compartment barriers shall be constructed and maintained to a 1/2 hour minimum fire resistance rating. Interview with maintenance personnel at the time of the observation acknowledged the unprotected penetrations and missing drywall, 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 19.3.7.3, 8.5.6.2 .	K 372	checklist. (D)Inspection sheets will be reviewed by the facility maintenance director and reported to the quality committee.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety	K 511	(A)To ensure the safety of staff and residents the electrical systems will be maintained to comply with NFPA 70	6/19/18

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K 511	Continued From page 4 Code. Failure to maintain electrical systems could result in injury or death in the event of an emergency. The deficiencies affected the mechanical equipment penthouse. The findings were: Observation on 05/16/2018 at 11:28 AM revealed the mechanical penthouse had an electrical disconnect with storage in front that was obstructing access. Electrical equipment shall be provided and maintained with adequate access and working space. Interview with maintenance personnel at the time of the observation acknowledged that the storage was obstructing access to the disconnect, and that he was aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1, 9.1.2; 2011 NFPA 70 110.26(A)	K 511	national electrical code and NFPA 2012 Life Safety Code. (B)The electrical disconnect will have all obstructions removed by maintenance personnel and a red line will be installed as a reminder to keep area clear for adequate access and working space. (C)All mechanical 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 maintenance director and reported to the quality committee.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		6/19/18

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K 521	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain heating, ventilating and air-conditioning equipment in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect mechanical equipment areas could result in injury or death by allowing the propogation of smoke and fire. The deficiency affected the mechanical equipment penthouse. The findings were: Observation on 05/16/2018 at 11:32 AM revealed the mechanical penthouse contained combustible storage including old carpet and bed frames in a room containing air handling equipment. Mechanical equipment rooms shall not have combustible materials stored in them. Interview with maintenance personnel at the time of the observation acknowledged the mechanical equipment penthouse was being used to store combustible material, and indicated he was not aware of the requirement. Interview with the Director of Nursing at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.2.1, 9.2.1, 2012 NFPA 90A 5.1.4, 2006 International Fire Code 315.2.3	K 521	(A)To ensure the safety of staff and residents the heating, ventilating and air condition equipment will be maintained in accordance with the NFPA 101 Life Safety Code. (B)The combustible storage will be removed from the mechanical penthouse by maintenance personnel and stored in an approved storage area. (C)All mechanical and storage areas will be inspected by maintenance personnel monthly and recorded on our preventative maintenance inspection checklist. (D)Inspection sheets will be reviewed by the facility maintenance director and reported to the quality committee.	

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 04/25/2018. .	E 000		
E 015	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 every 2 years (annually for LTC). 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		6/14/18

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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 documentation review and staff interview the facility failed to provide policies and procedures addressing subsistence needs for patients and staff. The findings were: Documentation review of the Emergency Preparedness Plan on 05/16/2018 at 1:00 PM revealed that no policy or procedure was available that addressed the subsistence needs for staff and patients in the event the facility must evacuate or shelter in place. Interview with the facility administrator acknowledged the deficiency, and revealed he was unaware that this requirement was missing from the plan. .	E 015	A.) The Facility Coordinator has developed an Emergency Preparedness policy and procedure addressing subsistence needs for staff and patients in the event the facility must evacuate or shelter in place. B.) The policy and procedure will be reviewed and updated at least annually by the Emergency Preparedness committee. C.) Results will be reported quarterly as part of the facility quality assurance program by the Facility Coordinator.	
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		6/14/18

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E 024	Continued From page 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 every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to provide policies and procedures for volunteers. The findings were: Documentation review of the Emergency Preparedness Plan on 05/16/2018 at 1:00 PM	E 024	A.) The Facility Coordinator has developed an emergency preparedness policy and procedure to address the use of volunteers in an emergency. B.) The policy and procedure will be reviewed and updated at least annually by	

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E 024	Continued From page 3 revealed that no policy or procedure was available that addressed the use of volunteers in an emergency. Interview with the facility administrator acknowledged the deficiency, and revealed he was unaware that this requirement was missing from the plan. .	E 024	the Emergency Preparedness committee. C.) Results will be reported quarterly as part of the facility quality assurance program by the Facility Coordinator.	
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(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 every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by:	E 026		6/14/18

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E 026	Continued From page 4 Based on documentation review and staff interview revealed that the facility failed to address roles under a waiver declared by the Secretary. The findings were: Documentation review of the Emergency Preparedness Plan on 05/16/2018 at 1:00 PM revealed that no policy or procedure was available that addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Interview with the facility administrator acknowledged the deficiency, and revealed he was unaware that this requirement was missing from the plan.	E 026	A.) The Facility Coordinator has developed an Emergency Preparedness policy and procedure addressing the role of the facility under a waiver declared by the secretary in the provision of care and treatment at an alternate care site identified by emergency management officials. B.) The policy and procedure will be renewed and updated at least annually by the Emergency Preparedness committee. C.) Results will be reported quarterly as part of the facility quality assurance program by the Facility Coordinator.	