STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on June 24, 2021.	E 000		
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:	E 031		7/14/21

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

Electronically Signed | 07/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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
E 031	Continued From page 1 (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed the facility failed to provide all required emergency officials contact information in the communications plan. The findings were: Review of the Emergency Preparedness Plan on 06/24/21 at 1:30 PM revealed the plan did not include the State licensing and certification agency's, nor the State's long term care ombudsman's, contact information. Interview with the administrator acknowledged the deficiency, and indicated they were unaware that this requirement was missing from the plan. .	E 031	The Hospital Preparedness Committee reviewed and accepted the changes that were made to our communication plan July 14, 2021. These changes included: 1. Updating phone numbers and staff in position on the communication phone numbers. 2. Adding: a. Wyoming Health Department b. Regional Ombudsman c. State Ombudsman d. Wyoming State Board of Nursing e. Wyoming Board of Medicine The Emergency Officials Contact Information will be reviewed every six months and will be updated as needed by the chairman of the Hospital Preparedness Committee. The person responsible for maintaining an emergency preparedness communication plan that complies with Federal, State, and local laws will be the chairman of the Hospital Preparedness Committee.	
E 042 SS=F	Integrated EP Program CFR(s): 483.73(f) §416.54(e), §418.113(e), §441.184(e),	E 042		7/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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
E 042	Continued From page 2 §460.84(e), §482.15(f), §483.73(f), §483.475(e), §484.102(e), §485.68(e), §485.625(f), §485.727(e), §485.920(e), §486.360(f), §491.12(e), §494.62(e). (e) [or (f)]Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program. (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered. (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program]. (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following: (i) A documented community-based risk assessment, utilizing an all-hazards	E 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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
E 042	Continued From page 3 approach. (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach. (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively. This REQUIREMENT is not met as evidenced by: Document review and staff interview revealed that the facility failed to provide a compliant unified and integrated emergency preparedness program. The findings were: Review of the Emergency Preparedness Plan on 06/24/21 at 1:30 PM revealed that the facility had an overall hazardous risk assessment for the health system which includes a certified hospital. However, the facility did not have documented individual facility based hazardous risk assessments for each separately certified facility within the health system. Interview with the administrator acknowledged the deficiency, and indicated they were unaware that this requirement was missing from the plan. .	E 042	Hospital Preparedness facilitated the completion of a HVA for the North Big Horn Hospital Clinic July 16, 2021 and it was finalized July 12, 2021. Hospital Preparedness facilitated the completion of a HVA for the New Horizons Care Center a.k.a. Care Center July 7, 2021 and it was finalized July 12, 2021. Hospital Preparedness will help facilitate a HVA for the North Big Horn Hospital and it will be completed and finalized no later than July 31, 2021. The HVA's for New Horizon Care Center, North Big Horn Hospital Clinic and North Big Horn Hospital will be reviewed and revised every two years to meet compliance. The Hospital Preparedness Committee with review all three HVA's (North Big Horn Clinic, North Big Horn Hospital and New Horizons Care Center)and will make	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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
E 042	Continued From page 4	E 042	any additions, deletions or corrections necessary so our EOP addresses the results of the HVA's. This review and finalization of our EOP will be completed no later than September 17, 2021. The person responsible for the completion of the three HVA's (North Big Horn Clinic, North Big Horn Hospital and New Horizons Care Center) will be the chairman of the Hospital Preparedness Committee.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on June 24th, 2021. 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 52 residents. .	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		7/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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 372	Continued From page 5 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 staff interview, the facility failed to maintain smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain smoke barriers could result in injury or death in the event of an emergency. The deficiency affected two (2) of three (3) smoke compartments on the second floor. The findings were: Observation on 06/24/21 at 11:20 AM revealed that the smoke barrier on the second floor separating the east resident wing from the central staff area had unprotected data wires and conduit penetrations above the ceiling. Penetrations of smoke barriers shall be protected by a system or material that restricts the transfer of smoke. Interview with the facility director at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the Administrator at the time of exit	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 on the second floor separating the east wing from the central area, will be fire chalked. (C)All smoke compartments will be inspected quarterly on a preventative maintenance inspection checklist. (D)Inspection sheets will be reviewed by the facility services director, and reported to the quality committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535030	A. BUILDING **01** B. WING _____	**06/24/2021**

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 372	Continued From page 6 acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.7.4, 8.5.6.2	K 372		