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 CE B. WING _____	12/14/2010

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 with a census of 82. 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 write an "F" in the Provider's Plan of Correction Completion Date columns. If the facility intends to correct the deficiency fill in the Provider's Plan of Correction column with the appropriate information and dates.	K 000		
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,	K 017	K017	"F"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Bass RN — TITLE: Acting Administrator — (X6) DATE: 1-7-2011

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
JAN 12 2011

FC accepted w/ Mary Bass, Acting NHA, on 1/13/11

Office of Healthcare Licensing and Surveys

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K 017	Continued From page 1 waiting areas, dining rooms, and activity spaces 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 12/14/10 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 12/14/10 at 9:30 AM confirmed the ventilation system was not ducted and the open plenum was used for the transfer of air. This deficiency can be obviated by the Fire Safety and Evaluation System (FSES). If the facility agrees to the conditions of the FSES write an "F" in the Provider's Plan of Correction and Completion Date columns. If the facility intends to correct the deficiency fill in the Provider's Plan of Correction column with the appropriate information and dates.	K 017		

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K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the double smoke barrier doors between 2 of 6 smoke compartments were smoke resistant. The findings were: Observation of the smoke barrier doors on 12/14/2010 at 1:49 PM showed the double doors leading to the 7/8 pod had a gap greater than 1/8th inch wide. The gap was 1/4th inch between the doors. At the time of observation the maintenance technician reported he was aware of the spacing requirement. He further reported the doors were inspected on a monthly basis, he could not explain why the door had not been noticed and modified.	K 027	K027 A)Fire and smoke resistant barriers will be maintained for the safety of residents and staff. B)A door astragal will be added to close the ¼" gap in the double doors. C)A visual inspection will be conducted monthly and documented on the Preventative Maintenance checklist. D)This checklist will be monitored for completion by the Facility Services Director. E)The results of these checklists will be reported quarterly to the Quality Committee.	01/28/11
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	K029 A)To insure the safety of the residents and staff, hazardous materials willnot be stored in unapproved areas. B)All hazardous items will be removed from the dining room.	01/28/11

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K 029	Continued From page 3 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	C)Visual inspections of non approved storage areas will be conducted monthly and documented on the Preventative Maintenance checklist. D)This checklist will be monitored for completion by the Facilities Services Director. E) The results of this checklist will be reported at quarterly Quality Committee meetings.	
K 046 SS=F	This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were: Observation of the pod 7 dining room on 12/14/10 at 1:10 PM showed five mattresses and 4 racks of clothes were being stored in the room. At the time of observation the maintenance technician reported the walls did not extend to the floor above. Furthermore, he reported that he was aware the amount of combustible items exceeded the volume allowed without complete separation. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 2 emergency battery light tests was performed. The findings were: Review of the emergency battery light test showed the annual 90-minute test was last done on 8/20/2009. On 12/14/10 at 9:30 AM the maintenance technician reported he was aware of	K 046	K046 A)Electrical Equipment will be maintained according to NFPA 70, to insure the safety of residents and staff. B)The 90 minute battery light test will be completed. C)The 90 minutes emergency light tests will be added to the yearly Preventative Maintenance checklist. D)The Preventative Maintenance checklist will be monitored for completion by the Facilities Services Director.	01/28/11

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K 046	Continued From page 4 the annual requirement and could not explain why the test had been missed.	K 046	E)The results of these checklists will be reported to the Quarterly Quality Committee meetings.	
K 062 SS=E	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 and free from foreign material in 2 of 6 smoke compartments. The findings were: 1. Observation of the sprinkler system on 12/14/10 at 9:37 AM showed 4 sprinkler heads in the kitchen were obstructed by ventilation diffusers, the heads were located less than 12 inches away from the diffusers and were 5 inches above the bottom of diffusers. At the time of observation the maintenance technician reported he was aware of the spacing requirement. Furthermore, he reported the system was inspected quarterly by an outside contractor and the last inspection on 11/11/2010 did not indicate any heads were obstructed. 2. Observation of the sprinkler system on 12/14/2010 at 10:40 AM showed one of three sprinkler heads in resident room #223 had sheet rock texture on the fusible link. At the time of observation the maintenance technician was aware painted or damaged heads were to be replaced.	K 062	K062 A)The automatic sprinkler system will be maintained in reliable operating condition for the safety of Residents and Staff. B)The sprinkler heads in the kitchen will be lowered so the ventilation diffusers will not obstruct sprinkler operation. The sprinkler head in Resident room #223 will be replaced. C)A visual inspection of the sprinkler system will be conducted quarterly and documented on the Preventative Maintenance checklist. D)The Preventative Maintenance Checklist will be reviewed for completion by the Facility Services Director. E)Results of the Preventative Maintenance checklist will be reported at quarterly Quality Committee meetings.	01/28/11
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

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K 064 SS=E	Continued From page 5 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 2 of 6 smoke compartments. The findings were: Observation of the portable fire extinguishers on 12/14/10 between 9:30 AM and 11 AM showed the "K" type extinguisher in the first floor East and West dining rooms had not received the required monthly inspections during November 2010. At 9:41 AM the maintenance technician reported he was aware of the testing requirement. He further reported the extinguishers were newly installed in October 2010, and the new testing log had not been used since their installation.	K 064	K064 A)Portable fire extinguishers will be maintained according to NFPA 10 for the safety of Residents and Staff. B)The portable fire extinguishers located in the east and west dining rooms will be inspected. C)These portable fire extinguishers will be added to the monthly Preventative Maintenance checklist. D)The Preventative Maintenance checklist will be monitored for completion by the Facilities Services Director. E)The Preventative Maintenance checklist will be reported at the quarterly Quality Committee meetings.	01/05/11
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure "NO SMOKING" signs were posted where oxygen was in use in 2 of 6 smoke compartments. The findings were:	K 141	K141 A)For the safety of our Residents, North Big Horn Hospital and New Horizons Care Center have been designated as a non-smoking campus. B)In accordance with NFPA 99 the Oxygen in Use Policy will be revised to state that the Hospital and Care Center are Non-Smoking campuses. All main entrances will be signed Non-Smoking	01/28/11

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K 141	Continued From page 6 Observation of resident rooms on 12/14/10 between 9:30 AM and 1:30 PM showed resident rooms #227, #202 and #338 had oxygen concentrators in use and corridor doors were not posted with "no smoking" signs. At 9:52 AM the maintenance technician reported he was aware areas with oxygen in use are required no smoking signage. Furthermore, he reported the posting of such signage was the responsibility of the nursing staff.	K 141	Campus, and No Smoking Oxygen in Use. C)The main entrance signage inspection will be added to the Preventative Maintenance semi-annual checklist. D)The Preventative Maintenance checklist will be reviewed for completion by the Facility Services Director. E)The Preventative Maintenance checklist will be reviewed at the quarterly Quality Committee meeting.	