STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NEW HORIZO...** B. WING	(X3) DATE SURVEY COMPLETED **09/23/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Horizons Care Center	**1111 Lane 12 , Lovell, Wyoming, 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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 09/23/2026. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this 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 (NFPA). The facility was a fully sprinklered, two story building of Type II (III) construction built in 1991. The building was equipped with a supervised, automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 85 certified Medicare and Medicaid beds with a census of 60 residents. The findings the follow demonstrate noncompliance with 42 CFR 483.90.	K0000		
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the battery-powered emergency lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly test and maintain the battery-powered emergency lighting could impede or prevent egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all battery-powered emergency lighting including exit signs and could potential affect all staff, patients, and visitors. Document review on 09/23/2026 starting at 12:00 PM revealed that the facility failed to conduct all	K0291	Corrective action: The Facilities Department will conduct a 100% facility inventory, visual inspection, and testing of all battery-powered emergency light units and exit signs across the Care Center Identification of other potential deficient practices: Facilities will audit all patient care areas, exit corridors, stairwells, generator rooms, and switchgear rooms to ensure no battery-operated fixture or exit sign was missed in the Care Center log Measures and systemic changes to prevent recurrence: Hold mandatory training for all Facilities staff regarding proper testing procedures, documenting testing results, and standard operating procedures for replacing failed units within the proper time frame Monitoring corrective action performance: Maintain written log pertaining; date of testing, location of lighting, type of test, pass/fail status. The Facilities Director will report on results of inspections at quarterly quality committee meetings	10/09/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535030	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - NEW HORIZO...** B. WING	(X3) DATE SURVEY COMPLETED **09/23/2026**

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K0291 SS = F Bldg. 01	Continued from page 1 required testing of the battery-powered emergency lighting. Documentation was available at the time of the survey to confirm the monthly thirty (30) second test of battery-powered emergency lighting was conducted during ten (10) of the last twelve (12) months. No documentation was available to confirm the thirty (30) second testing was conducted in April or May of 2026. No documentation was available at the time of the survey to confirm that the annual ninety (90) minute test had been conducted. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated that they were aware of the requirement. Interview with the CEO on 09/23/2026 at 1:15 PM during the exit confirmed the deficiency. Ref: 2012 NFPA 101 19.2.9.1, 7.9.3.1	K0291	Continued from page 1 Timeframe of completion: Corrective action will be completed no later than October 9, 2026	10/09/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by:	K0921	Corrective action: Identify all PCREE lacking documented safety testing and perform physical and electrical safety testing Identification of other potential deficient practices: Preform an audit of all resident rooms, medical supply rooms, therapy areas, and nursing stations to identify every piece of PCREE Measure and systemic changes to prevent recurrence: Establish routine annual electrical safety testing schedules measuring chassis leakage current and ground chain resistance Monitoring corrective action performance: Implement audits of new intake inspections and preventative maintenance completion logs monthly. The Facilities Director will report on results of testing at quarterly quality committee meetings. Timeframe of completion: Corrective action will be completed no later than October 31, 2026	10/31/2026

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K0921 SS = F Bldg. 01	Continued from page 2 Based on document review and staff interview, the facility failed to test and maintain the Patient Care Related Electrical Equipment (PCREE) in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain PCREE could result in a failure of the equipment, resulting in injury or death. The deficiency affected PCREE in the facility, and could potentially affect all patients and staff that utilize the equipment. Document review on 09/23/26 starting at 12:00 PM revealed that the facility failed to test all PCREE for electrical safety. No documentation was available at the time of the survey to confirm that the facility was conducting the required electrical safety testing. The physical integrity, resistance, leakage current, and touch current tests shall be conducted before PCREE is put into service and after any repair or modification that might compromise electrical safety. Testing shall be performed for all appliances intended for diagnosis, therapy, or monitoring, including electric beds. Interview with the facility manager at the time of the observation acknowledge the deficiency, and indicated they were unaware of the requirement. Interview with the CEO on 09/23/2026 at 1:15 PM confirmed the deficiency. Ref: 2012 NFPA 99 10.3	K0921		10/31/2026
K0372 SS = E Bldg. 01	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 STANDARD is NOT MET as evidenced by:	K0372	Corrective action: Apply fire caulk to all smoke barrier wall penetrations identified Identification of other potential deficient practices: Facilities will complete a visual and physical inspection above the lay-in ceiling tiles along the entire length of every smoke barrier wall in the Care Center Measures and systemic changes to prevent recurrence: Update the PM log to include quarterly visual inspections above ceilings along all smoke barrier lines Monitoring corrective action performance: The Facilities Director will perform periodic audits of random smoke barrier wall lengths to ensure adherence to the Life Safety Code and report on results of inspections at quarterly quality committee meetings	10/09/2026

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K0372 SS = E Bldg. 01	Continued from page 3 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 the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments on the first floor, and has the potential to affect residents, staff, and visitors in those areas. Observation on 09/23/2026 at 11:42 AM revealed unprotected penetrations of a smoke barrier. Observation of the first floor smoke compartment revealed multiple conduit and sprinkler piping penetrations above the drop ceiling that were not properly protected. Smoke barriers shall be constructed to have a minimum 1/2 hour fire rating and all penetrations shall be protected by a system that is capable of limiting the transfer of smoke. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirements. Interview with the CEO on 09/23/2026 at 1:15 PM confirmed the deficiency. Reference: 2012 NFPA 101 19.3.7.3; 8.4.4.1	K0372	Continued from page 3 Timeframe of completion: Corrective action will be completed no later than October 9, 2026	10/09/2026
K0374 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect openings in smoke barriers in accordance with the 2012 NFPA 101, Life Safety	K0374	Corrective action: Install a UL-listed, surface-mounting self-closing door closer on the cited door Identification of other potential deficient practices: Inspect each door along the smoke barrier for required closing hardware, proper operation, and magnetic release upon alarm activation Measures and systemic changes to prevent recurrence: Reinforce current monthly PM routine for inspection of 100% of door closers, hinges, latching mechanisms, and automatic hold-open releases along all smoke barrier walls Monitoring corrective action performance: The Facilities Director will report on results of inspections at quarterly quality committee meetings Timeframe of completion: Corrective action will be completed no later than October 16, 2026	10/16/2026

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K0374 SS = E Bldg. 01	Continued from page 4 Code. Failure to properly protect openings in smoke barriers could result in the spread of smoke and fire, resulting in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments on the first floor, and has the potential to affect all residents, staff, and visitors in those areas. Observation on 09/23/2026 at 11:55 AM revealed a non-compliant door in the first floor smoke barrier. Observation of the first floor smoke barrier revealed an office door, adjacent to room 2157, that was not self-closing or automatic closing. Observation revealed screw holes in the door frame where a door closer had been installed, but was now removed. Doors in smoke barriers shall be self-closing or automatic closing. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the CEO on 09/23/2026 at 1:15 PM confirmed the deficiency. Reference: 2012 NFPA 101 19.3.7.8	K0374		10/16/2026

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E0000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 09/23/2026. Based on the findings of the survey team, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.	E0000		

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