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

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 05 - ROBERTS ADMINISTRATION BUILDING B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE DRIVE SHERIDAN, WY 82801

(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	K 000		

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, New Health Care, of the National Fire Protection Association (NFPA).

The facility was a non-sprinkled single story building of Type V (111) construction with plan approval in 2010. The building was equipped with an addressable fire alarm system. This building meets the Life Safety Code standards based on compliance with all provisions.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski | TITLE: Administrator | (X6) DATE: 8/19/13

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.

Rec'd Adopted w/ CMS Szymanski, NHA, DN 8/21/13.

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	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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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, New Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2010. The building was equipped witha supervised automatic dry sprinkler system and an addressable fire alarm system. The building had a capacity of 12 certified Medicare and Medicaid beds.	K 000		
K 027 SS=D	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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		7/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski
TITLE: Administrator
(X6) DATE: 8/19/13

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.

ACCEPTED W/ CHRIS SZYMANSKI, NHA, ON 8/21/13.

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K 027	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two smoke barrier doors were resistant to the passage of smoke. The findings were: Observation on 6/26/13 at 10:33 AM revealed the cross corridor smoke barrier doors between the two smoke compartments did not close completely during a fire drill. Maintenance staff verified this finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self closing or automatic closing in accordance with 19.2.2.2.6. 8.3.4.1 Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	Founders K-027-Adjustments were made to the cross corridor smoke barrier doors on 7/18/13 to ensure closure between the two smoke compartments. The door closure will be tested monthly during fire drills to ensure complete door closure between the two smoke compartments and noted in the TELS system. Any negative trends will be reported to the Safety Committee and addressed with a plan of correction. Follow up on the results will be reported to the quarterly QA meeting.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 029	K029-To ensure hazardous areas are	7/19/13

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K 029	Continued From page 2 facility failed to ensure hazardous areas were separated from use areas in 1 of 2 smoke compartments. The findings were: Observation on 6/26/13 at 1:32 PM revealed the door to the pantry room had a SCD attached to the door however, the door failed to close upon three separate attempts. Maintenance staff confirmed the findings at the time of the observation. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.2, 8.2.4.3.5 18.3.2.1 Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. 8.4.1.2 In new construction, where protection is provided with automatic extinguishing systems without fire-resistive separation, the space protected shall be enclosed with smoke partitions in accordance with 8.2.4. 8.2.4.3.5 Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. 7.2.1.8.1 Self Closing Devices. A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing in accordance with	K 029	separated from use areas in smoke compartments, the door to the pantry room was repaired on 7/19/13. Doors will be checked on a weekly basis by maintenance staff to assure that the smoke barrier is intact and that the self-closing doors latch effectively. Negative trends and repairs will be reported to the Safety Committee and a plan of action initiated. Results and any ongoing concerns will be taken to QA for review.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water	K 056		7/19/13

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K 056	Continued From page 3 supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two sprinkler heads in 1 of 2 smoke compartments were installed as required. The findings were: Observation on 6/26/13 at 10:33 AM revealed a ceiling mounted sprinkler head in the bathroom of resident room #3 was missing an escutcheon. Maintenance staff confirmed the finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition. Section 18.3.5.1 (new) Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Section 9.7.1.1 each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 1999 Edition. 1999 NFPA 13 2-2.6.2 Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 056	K056-To install sprinkler heads as required, the escutcheon was repaired in the bathroom of resident room #3 on 7/19/13. Weekly walk-throughs will be conducted by maintenance staff to visually inspect the status of the sprinkler heads. Any items found by other staff or maintenance will be noted on a TELS work order and fixed as soon as possible. Negative trends will be reported to the Safety Committee and a plan of action will be implemented. The results of the plan of action will be reported to the QA Committee.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		7/22/13

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K 062	Continued From page 4 condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation and staff interview the facility failed to ensure the fire suppression (sprinkler) system was properly maintained in 1 of 2 smoke compartments. The findings were: 1. Observation on 6/26/13 at 12:11 PM revealed a gap greater than one half inch existed between the sprinkler head escutcheon and the ceiling in the bathroom of resident room #2. In addition, storage material in the closet of resident room #11 was stored less than 8 inches from the sprinkler head. Maintenance staff confirmed the findings at the time of the observations. Reference: NFPA 101, Life Safety Code, 2000 edition. Section 9.7.1.1 Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. Section 18.3.5.1 (new) Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Section 9.7.4.2. Where standpipe and hose systems are installed in combination with automatic sprinkler systems, installation shall be in accordance with the appropriate provisions established by NFPA 13 Standard for the Installation of Sprinkler Systems. NFPA 13 Standards for the Installation of	K 062	1. Gap was repaired on sprinkler head escutcheon in the bathroom of resident rooom #2 on 7/22/13. Also, there was no material stored within 18" of the sprinkler head within the closet of resident room #11 on 7/22/13. Maintenance staff will check the sprinkler heads to ensure that there are no gaps on their monthly rounds for resident rooms. The findings will be reported to the Safety Committee where a plan of actin will be initiated. The results of the action plan will be reported to the QA Committee.	

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K 062	Continued From page 5 Sprinkler Systems, 1999 Edition: 5-6.5.3* Obstructions that prevent Sprinkler Discharge from Reaching the Hazard. Continuous or noncontinuous obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section.	K 062		

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	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING	06/26/2013

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K 000	INITIAL COMMENTS	K 000		

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, New Health Care, of the National Fire Protection Association (NFPA).

The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2010. The building was equipped with a supervised automatic dry sprinkler system and an addressable fire alarm system. The building had a capacity of 12 certified Medicare and Medicaid beds.

K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 012		7/17/13

Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure smoke barriers were maintained as a continuous membrane in 1 of 2 smoke compartments. The findings were:

Observation on 6/26/13 between 11:22 AM revealed an approximate 1" diameter hole in the ceiling of the staff locker room. Maintenance staff confirmed the observation at the above stated time.

Reference: NFPA 101, Life Safety Code, 2000 edition.

Whitney
K-012-to ensure that smoke barriers are maintained as a continuous membrane, the hole in the ceiling of the staff locker room was repaired on 7/17/13.
Observation of the common area ceiling covers is included in the maintenance weekly inspection walk-throughs. Once discovered, any deficiencies will be repaired as soon as possible. If a vent cover is loose or missing and found by other staff members, maintenance will be notified via TELS work

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chris Szymanski	Administrator	8/19/13

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PLAN ACCEPTED W/ CHRIS SZYMANSKI, NHA, ON 8/21/13.

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8/21/13

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K 012	Continued From page 1 19.3.6.2.2* Corridor walls and ceilings shall form a barrier to limit the transfer of smoke.	K 012	order. Negative trends in the vent coverage will be reported to the Safety Committee and plans of correction developed. Follow up on the results will be reported at the quarterly QA Committee meeting.	
K 027 SS=D	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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		7/18/13
	This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 1 smoke barrier door was resistant to the passage of smoke. The findings were:		K-027-Adjustments were made to the cross corridor smoke barrier doors on 7/18/13 to ensure closure between the two smoke compartments. The door closure will be tested	

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K 027	Continued From page 2 Observation on 6/26/13 at 11:48 AM revealed the cross corridor smoke barrier doors between the two smoke compartments did not close completely during a fire drill. Maintenance staff verified this finding at the time of the observations. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self closing or automatic closing in accordance with 19.2.2.2.6. 8.3.4.1 Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	monthly during fire drills to ensure complete door closure between the two smoke compartments. The door closure will be tested monthly during fire drills to ensure complete door closure between the two smoke compartments and noted in the TELS system. Any negative trends will be reported to the Safety Committee and addressed with a plan of correction. Follow up on the results will be reported to the quarterly QA meeting.	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure the fire alarm system was maintained in 1 of 4 nursing buildings. The findings were: 1. Record review revealed Simplex-Grinnell Inc. conducted a facility wide inspection of the fire	K 052	K052 - On 7/19/13, the contractor, Simplex Grinnell, conducted a facility-wide inspection of the fire alarm system. All previously mentioned system problems were addressed and repaired for all 4 cottages. Upon receipt of the fire alarm report, Maintenance Director will double check to	7/19/13

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K 052	Continued From page 3 alarm system on 3/4/13. The inspection revealed three system problems including "4 auxiliary controls, one control panel-Multiplex and 2 door handlers". Maintenance manager was unable to provide documentation the three problems were fixed. Reference: NFPA 101, Life Safety Code, 2000 edition. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code.	K 052	assure all systems are compliant before the contractor leaves, or have a plan in place to address the failures as soon as possible. The results of the fire alarm system testing and maintenance will be reported to the Safety Committee; A plan of action will be implemented for negative findings. Results of the plan will be reported to the QA Committee.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two sprinkler heads in 1 of 2 smoke compartments were installed as	K 056	K056-Escutcheon was installed on ceiling mounted sprinkler head in the ceiling of the locker room on 7/19/13.	7/19/13

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	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING _____	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

8/21/13

(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 056	Continued From page 4 required. The findings were: Observation on 6/26/13 at 10:11 AM revealed a ceiling mounted sprinkler head in the ceiling of the locker room in the Whitney building was missing an escutcheon. Maintenance staff confirmed the finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition. Section 18.3.5.1 (new) Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Section 9.7.1.1 each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems, 1999 Edition. 1999 NFPA 13 2-2.6.2 Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 056	Weekly walk-throughs will be conducted by maintenance staff to visually inspect the status of the sprinkler heads. Any items found by other staff or maintenance will be noted on a TELS work order and fixed as soon as possible. Negative trends will be reported to the Safety Committee and a plan of action will be implemented. The results of the plan of action will be reported to the QA Committee.	

WY Dept of Health

AUG 19 2013

Provider Licensing

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 02 - WATT BUILDING B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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, New Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2010. The building was equipped with a supervised automatic dry sprinkler system and an addressable fire alarm system. The building had a capacity of 12 certified Medicare and Medicaid beds.	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure smoke barriers were maintained as a continuous membrane in 1 of 2 smoke compartments. The findings were: Observation on 6/26/13 at 10:48 AM revealed 3 vent adjustable covers missing in the ceiling. Maintenance staff confirmed the observation at the above stated time. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.3.6.2.2* Corridor walls and ceilings shall form	K 012	Watt K-012-three adjustable vent covers in the ceiling of Building 02 (Watt) were repaired on 7/17/13 to ensure the holes were sealed. Observation of the ceiling covers is included in the maintenance monthly inspection walk-throughs. Once discovered, any deficiencies will be repaired as soon as possible. If a vent cover is loose or missing and found by other staff members, maintenance will be notified via TELS work order.	7/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski | TITLE: Administrator | (X6) DATE: 8/19/13

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.

ACCEPTED W/ CHRIS SZYMANSKI, NHA, ON 8/21/13.

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

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	535054	A. BUILDING 02 - WATT BUILDING B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

8/21/13

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K 012	Continued From page 1 a barrier to limit the transfer of smoke.	K 012	Negative trends in the vent coverage will be reported to the Safety Committee and plans of correction developed. Follow up on the results will be reported at the quarterly QA Committee meeting.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure one corridor door was resistant to the passage of smoke in 1 of 2 smoke compartments. The findings were: Observation on 6/26/13 at 11:11 AM revealed the corridor door to the bathroom did not close completely in its frame. Closer observation revealed the door was significantly warped. Maintenance staff verified this finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition, Section 18.3.6.3.1 (new) Doors protecting corridor openings shall be constructed to resist the passage of smoke.	K 018	K018/-Corridor door to the bathroom was repaired to close completely in its frame on 7/9/13. Common area door operation will be checked weekly by maintenance. If a door is not latching properly, then it will be reported to maintenance via TELS work order. Concerns or multiple deficiencies in door latching will be reported to the Safety Committee and trends reported to the QA Committee.	7/9/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance	K 029		7/19/13

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	535054	A. BUILDING 02 - WATT BUILDING B. WING _____	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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 029	Continued From page 2 with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 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 2 smoke compartments. The findings were: Observation on 6/26/13 at 1:12 PM revealed the following: 1. One vent adjustable cover was missing in the ceiling of the oxygen storage room. 2. The door to the dry storage room and the laundry room had a self closure devices (SCD) attached to the doors however, the doors failed to close upon three separate attempts. Maintenance staff confirmed the findings at the time of the observations. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.2, 8.2.4.3.5 18.3.2.1 Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. 8.4.1.2 In new construction, where protection is provided with automatic extinguishing systems without fire-resistive separation, the space protected shall be enclosed with smoke partitions in accordance with 8.2.4. 8.2.4.3.5 Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. 7.2.1.8.1 Self Closing Devices. A door normally	K 029	K-029-To ensure hazardous areas are separated from use areas in smoke compartments, the vent adjustable cover was replaced in the ceiling of the oxygen storage room on 7/18/13. The door to the dry storage and laundry rooms were repaired to close completely on 7/19/13. Common area vent covers and doors will be checked on a weekly basis by maintenance staff to assure that the smoke barrier is intact and that the self-closing doors latch effectively. Negative trends and repairs will be reported to the Safety Committee. Any ongoing concerns will be taken to QA for review.	

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	535054	A. BUILDING 02 - WATT BUILDING B. WING _____	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(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 029	Continued From page 3 required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing in accordance with	K 029		

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	535054	A. BUILDING 01 - SCOTT BUILDING B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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K 000	INITIAL COMMENTS	K 000		

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, New Health Care, of the National Fire Protection Association (NFPA).

The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2010. The building was equipped with a supervised automatic dry sprinkler system and an addressable fire alarm system. The building had a capacity of 12 certified Medicare and Medicaid beds. This building meets the Life Safety Cod standards based on compliance with all provisions.

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

Chad Szymanski — Administrator — 8/19/13

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.

FOR ACCEPTED W/ CHAD SZYMANSKI, NHA, ON 8/21/13.