PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 01 - SCOTT BUILDING B. WING	01/15/2020

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 15th, 2020. Requirements for Long Term Nursing Homes 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 sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 11.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress could result in injury or death in the event of an	K 211	Green House Living for Sheridan will maintain snow removal of sidewalks outside of all spa room exits, which will be included as snow removal is completed with all other emergency exit routes. The Maintenance Director has added snow removal by spa door exits to their list of duties for inclement weather to ensure it is completed.	01/17/2020

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

Michelle Craig | Administrator | 2/7/2020

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.

POC approved via phone call with Administrator Michelle Craig on 02/11/20 at 3:10 PM Heather Schaumann

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GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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K 211	Continued From page 1 emergency. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Observation on 01/15/20 at 12:50 PM revealed that the exterior exit discharge from the spa room had not been cleared of snow. All means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in case of an emergency. Interview with the maintenance manager 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 acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.1, 7.1.10.1	K 211	The Maintenance Director will report success of completion of the duty at the monthly safety meeting as necessary. Monitoring of the snow removal by the spa door exits will be added to the Quality Assurance Performance Improvement (QAPI) program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	
K 291 SS=D	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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency battery-operated lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain emergency battery-operated lighting could result in injury or death in the event of an emergency. The deficiency affected one (1) of	K 291	Green House Living for Sheridan will ensure that all emergency lighting testing is completed at the required intervals. The 30 second monthly testing and the 90 minute annual testing of emergency lighting has been added to the facility's TELS building management software system to ensure completion. The Maintenance Director has created a checklist to document the testing and any finding and/or interventions. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting.	01/31/2020

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K 291	Continued From page 2 two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not conducted the thirty second or ninety minute tests of the emergency battery-operated lights in the last twelve months. All emergency battery-operated lighting must be tested monthly for thirty seconds and annually for ninety minutes. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1	K 291	Monitoring of the emergency battery-operated lighting testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		

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K 324	Continued From page 3 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and clean the kitchen hood exhaust system in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and clean the kitchen hood exhaust system could result in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility did not inspect and clean the kitchen hood exhaust system within the last twelve months. The kitchen hood exhaust system shall be inspected once every six months and cleaned as necessary in accordance with NFPA 96. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement.	K 324	Green House Living for Sheridan will ensure the proper inspection and cleaning of the kitchen hood exhaust systems in all four cottages. The Maintenance Director will procure a contract with an outside vendor to have the kitchen hood exhaust system inspected once every six months and cleaned as necessary in accordance with NFPA 96. The inspections have been added to the facility's TELS building management software system to ensure completion. The Maintenance Director will report on the inspections and necessary cleanings at the monthly safety meeting. Monitoring of the inspection and cleaning of the kitchen hood exhaust systems will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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K 324	Continued From page 4 Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 Table 11.4	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had conducted inspection and load voltage testing of the fire alarm system batteries once in the last twelve months. The fire alarm system batteries must be inspected and tested once every six months. Interview with the maintenance manager at the	K 345	Green House Living for Sheridan will ensure testing of the fire alarm system batteries every six months. The Maintenance Director has arranged with an outside vendor to test the fire alarm system batteries every six months and provide the facility with the appropriate documentation of the testing and any findings and/or interventions needed. The fire alarm system battery testing has been added to the facility's TELS building management software to ensure timely completion. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting as necessary. Monitoring of the fire alarm system battery testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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K 345	Continued From page 5 time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.3.1(3), Table 14.4.5(6)(3)	K 345		
K 511 SS=E	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 document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain the fire dampers could result in injury or death in the event of a fire. The deficiency affected two (2) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM	K 511	Green House Living for Sheridan will ensure fire damper inspections are performed every four years as per NFPA 80 guidelines. The inspection of fire dampers has been added the facility's TELS building management software system to ensure the timely scheduling and completion of this task. The facility will maintain a log documenting the inspections and any findings and/or interventions needed. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting as necessary. Monitoring of the fire damper inspections will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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K 511	Continued From page 6 revealed that the facility had not tested the fire dampers within the previous four years. Fire dampers shall be tested once every four years in accordance with NFPA 80. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1.1, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 19.4.1.1	K 511		

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	535054	A. BUILDING 02 - WATT BUILDING B. WING _____	01/15/2020

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 15th, 2020. Requirements for Long Term Nursing Homes 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 sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 12.	K 000		
K 291 SS=D	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, 18.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency battery-operated lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain emergency battery-operated lighting could result in injury or death in the event of an emergency. The deficiency affected one (1) of two (2) smoke compartments.	K 291	Green House Living for Sheridan will ensure that all emergency lighting testing is completed at the required intervals. The 30 second monthly testing and the 90 minute annual testing of emergency lighting has been added to the facility's TELS building management software system to ensure completion. The Maintenance Director has created a checklist to document the testing and any finding and/or interventions. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting. Monitoring of the emergency battery-operated lighting testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	01 31 2020

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

Michelle Craig | Administrator | 2/7/2020

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.

POC approved via phone call with Administrator Michelle Craig on 02/11/20 at 3:10PM Monica Thunemann

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K 291	Continued From page 1 The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not conducted the thirty second or ninety minute tests of the emergency battery-operated lights in the last twelve months. All emergency battery-operated lighting must be tested monthly for thirty seconds and annually for ninety minutes. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1	K 291		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		

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K 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and clean the kitchen hood exhaust system in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and clean the kitchen hood exhaust system could result in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility did not inspect and clean the kitchen hood exhaust system within the last twelve months. The kitchen hood exhaust system shall be inspected once every six months and cleaned as necessary in accordance with NFPA 96. Interview with the maintenance manager 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 acknowledged the deficiency.	K 324	Green House Living for Sheridan will ensure the proper inspection and cleaning of the kitchen hood exhaust systems in all four cottages. The Maintenance Director will procure a contract with an outside vendor to have the kitchen hood exhaust system inspected once every six months and cleaned as necessary in accordance with NFPA 96. The inspections have been added to the facility's TELS building management software system to ensure completion. The Maintenance Director will report on the inspections and necessary cleanings at the monthly safety meeting. Monitoring of the inspection and cleaning of the kitchen hood exhaust systems will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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K 324	Continued From page 3 Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 Table 11.4	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility conducted inspection and load voltage testing of the fire alarm system batteries once in the last twelve months. The fire alarm system batteries must be inspected and tested once every six months. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the	K 345	Green House Living for Sheridan will ensure testing of the fire alarm system batteries every six months. The Maintenance Director has arranged with an outside vendor to test the fire alarm system batteries every six months and provide the facility with the appropriate documentation of the testing and any findings and/or interventions needed. The fire alarm system battery testing has been added to the facility's TELS building management software to ensure timely completion. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting as necessary. Monitoring of the fire alarm system battery testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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	535054	A. BUILDING 02 - WATT BUILDING B. WING _____	01/15/2020

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 345	Continued From page 4 requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.3.1(3), Table 14.4.5(6)(3)	K 345		
K 511 SS=E	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 document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain the fire dampers could result in injury or death in the event of a fire. The deficiency affected two (2) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not tested the fire dampers within the past four years. Fire dampers	K 511	Green House Living for Sheridan will ensure fire damper inspections are performed every four years as per NFPA 80 guidelines. The inspection of fire dampers has been added the facility's TELS building management software system to ensure the timely scheduling and completion of this task. The facility will maintain a log documenting the inspections and any findings and or interventions needed. The Maintenance Director will report on any findings and or interventions at the monthly safety meeting as necessary. Monitoring of the fire damper inspections will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536064	A. BUILDING 02 - WATT BUILDING B. WING _____	01/15/2020

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 511	Continued From page 5 shall be tested once every four years in accordance with NFPA 80. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1.1, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 19.4.1.1	K 511		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING	01/15/2020

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 15th, 2020. Requirements for Long Term Nursing Homes 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 sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 10.	K 000		
K 291 SS=D	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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency battery-operated lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain emergency battery-operated lighting could result in injury or death in the event of an emergency. The deficiency affected one (1) of two (2) smoke compartments.	K 291	Green House Living for Sheridan will ensure that all emergency lighting testing is completed at the required intervals. The 30 second monthly testing and the 90 minute annual testing of emergency lighting has been added to the facility's TELS building management software system to ensure completion. The Maintenance Director has created a checklist to document the testing and any finding and or interventions. The Maintenance Director will report on any findings and or interventions at the monthly safety meeting. Monitoring of the emergency battery-operated lighting testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	01 31 2020

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

Michelle Craig — Administrator — 2/7/2020

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.

POC approved via phone call with Administrator Michelle Craig on 02/11/20 at 3:10 PM Heather Hanemann

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING _____	01/15/2020

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 291	Continued From page 1 The findings were: Document review on 01/15/20 at 2:15 PM revealed the facility had not conducted the thirty second or ninety minute tests of the emergency battery-operated lights in the last twelve months. All emergency battery-operated lighting must be tested monthly for thirty seconds and annually for ninety minutes. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1	K 291		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING _____	01/15/2020

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 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and clean the kitchen hood exhaust system in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and clean the kitchen hood exhaust system could result in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility did not inspect and clean the kitchen hood exhaust system in the last twelve months. The kitchen hood exhaust system shall be inspected once every six months and cleaned as necessary in accordance with NFPA 96. Interview with the maintenance manager 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 acknowledged the deficiency.	K 324	Green House Living for Sheridan will ensure the proper inspection and cleaning of the kitchen hood exhaust systems in all four cottages. The Maintenance Director will procure a contract with an outside vendor to have the kitchen hood exhaust system inspected once every six months and cleaned as necessary in accordance with NFPA 96. The inspections have been added to the facility's TELS building management software system to ensure completion. The Maintenance Director will report on the inspections and necessary cleanings at the monthly safety meeting. Monitoring of the inspection and cleaning of the kitchen hood exhaust systems will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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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 324	Continued From page 3 Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 Table 11.4	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility conducted inspection and load voltage testing of the fire alarm system batteries once in the last twelve months. The fire alarm system batteries must be inspected and tested once every six months. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the	K 345	Green House Living for Sheridan will ensure testing of the fire alarm system batteries every six months. The Maintenance Director has arranged with an outside vendor to test the fire alarm system batteries every six months and provide the facility with the appropriate documentation of the testing and any findings and/or interventions needed. The fire alarm system battery testing has been added to the facility's TELS building management software to ensure timely completion. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting as necessary. Monitoring of the fire alarm system battery testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02/20/2020

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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 345	Continued From page 4 requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.3.1(3), Table 14.4.5(6)(3)	K 345		
K 511 SS=E	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 document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain the fire dampers could result in injury or death in the event of a fire. The deficiency affected two (2) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not tested the fire dampers within the past four years. Fire dampers	K 511	Green House Living for Sheridan will ensure fire damper inspections are performed every four years as per NFPA 80 guidelines. The inspection of fire dampers has been added the facility's TELS building management software system to ensure the timely scheduling and completion of this task. The facility will maintain a log documenting the inspections and any findings and or interventions needed. The Maintenance Director will report on any findings and or interventions at the monthly safety meeting as necessary. Monitoring of the fire damper inspections will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02.20.2020

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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 511	Continued From page 5 shall be tested once every four years in accordance with NFPA 80. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1.1, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 19.4.1.1	K 511		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535064	A. BUILDING 04 - FOUNDERS BUILDING B. WING	01/15/2020

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on January 15th, 2020. Requirements for Long Term Nursing Homes 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 sprinkled, single-story building of Type V(111) construction that was built in 2008. The building was equipped with a supervised, automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 12 certified Medicare and Medicaid beds with a census of 12.	K 000		
K 291 SS=D	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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain emergency battery-operated lighting in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain emergency battery-operated lighting could result in injury or death in the event of an emergency. The deficiency affected one (1) of two (2) smoke compartments.	K 291	Green House Living for Sheridan will ensure that all emergency lighting testing is completed at the required intervals. The 30 second monthly testing and the 90 minute annual testing of emergency lighting has been added to the facility's TELS building management software system to ensure completion. The Maintenance Director has created a checklist to document the testing and any finding and/or interventions. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting. Monitoring of the emergency battery-operated lighting testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	01 31-2020

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

Michelle Craig Administrator 2/7/2020

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.

POC approved via phone call with Administrator Michelle Craig on 02/11/20 at 3:10PM Martha Shawerman

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING _____	01/15/2020

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 291	Continued From page 1 The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not conducted the thirty second or ninety minute tests of the emergency battery-operated lights in the last twelve months. All emergency battery-operated lighting must be tested monthly for thirty seconds and annually for ninety minutes. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.9.1, 7.9.3.1.1	K 291		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		

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	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING _____	01/15/2020

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 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and clean the kitchen hood exhaust system in accordance with the 2012 NFPA 101, Life Safety Code. Failure to inspect and clean the kitchen hood exhaust system could result in injury or death in the event of a fire. The deficiency affected one (1) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility did not inspect and clean the kitchen hood exhaust system in the last twelve months. The kitchen hood exhaust system shall be inspected once every six months and cleaned as necessary in accordance with NFPA 96. Interview with the maintenance manager 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 acknowledged the deficiency.	K 324	Green House Living for Sheridan will ensure the proper inspection and cleaning of the kitchen hood exhaust systems in all four cottages. The Maintenance Director will procure a contract with an outside vendor to have the kitchen hood exhaust system inspected once every six months and cleaned as necessary in accordance with NFPA 96. The inspections have been added to the facility's TELS building management software system to ensure completion. The Maintenance Director will report on the inspections and necessary cleanings at the monthly safety meeting. Monitoring of the inspection and cleaning of the kitchen hood exhaust systems will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02.20.2020

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K 324	Continued From page 3 Reference: 2012 NFPA 101 19.3.2.5.3(10); 2011 NFPA 96 Table 11.4	K 324		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to test and maintain the fire alarm system could result in injury or death in the event of a fire. The deficiency affected the fire alarm system. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility conducted inspection and load voltage testing of the fire alarm system batteries once in the last twelve months. The fire alarm system batteries must be inspected and tested once every six months. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the	K 345	Green House Living for Sheridan will ensure testing of the fire alarm system batteries every six months. The Maintenance Director has arranged with an outside vendor to test the fire alarm system batteries every six months and provide the facility with the appropriate documentation of the testing and any findings and/or interventions needed. The fire alarm system battery testing has been added to the facility's TELS building management software to ensure timely completion. The Maintenance Director will report on any findings and/or interventions at the monthly safety meeting as necessary. Monitoring of the fire alarm system battery testing will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02-20-2020

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	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING _____	01/15/2020

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 345	Continued From page 4 requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2010 NFPA 72 Table 14.3.1(3), Table 14.4.5(6)(3)	K 345		
K 511 SS=E	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	K 511		
	This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain fire dampers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to test and maintain the fire dampers could result in injury or death in the event of a fire. The deficiency affected two (2) of two (2) smoke compartments. The findings were: Document review on 01/15/20 at 2:15 PM revealed that the facility had not tested the fire dampers within the past four years. Fire dampers		Green House Living for Sheridan will ensure fire damper inspections are performed every four years as per NFPA 80 guidelines. The inspection of fire dampers has been added the facility's TELS building management software system to ensure the timely scheduling and completion of this task. The facility will maintain a log documenting the inspections and any findings and or interventions needed. The Maintenance Director will report on any findings and or interventions at the monthly safety meeting as necessary. Monitoring of the fire damper inspections will be added to the QAPI program and reviewed quarterly to ensure compliance. Responsible: Maintenance Director	02.20.2020

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K 511	Continued From page 5 shall be tested once every four years in accordance with NFPA 80. Interview with the maintenance manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.5.1.1, 9.2.1; 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 19.4.1.1	K 511		

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on January 15th, 2020.	E 000		
E 015 SS=F	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		

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

Michelle Craig | Administrator | 2/7/2020

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.

POC approved via phone call with Administrator Michelle Craig on 02/11/20 at 3:10PM Martie Shauermann

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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 document review and staff interview, the facility failed to address all subsistence needs in their Emergency Preparedness Plan policies and procedures. The findings were: Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that the policies and procedures did not address all subsistence needs for staff and patients including food, medical supplies or pharmaceutical supplies. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement.	E 015	Green House Living for Sheridan will ensure that the facilities Emergency Preparedness Plan will address all subsistence needs for staff and patients including food, medical supplies or pharmaceutical supplies. The Interdisciplinary Team will meet to review the facility's emergency preparedness plan to ensure the plan addresses all subsistence needs for staff and patients including food, medical supplies or pharmaceutical supplies and is in compliance with current regulatory requirements. All Emergency Preparedness Policies & Procedure binders will be updated with the newest emergency preparedness plan which will include this information and the Maintenance Director will educate staff regarding any additions or changes that were made to the plan. The Maintenance Director will report on any updates or additions to the Emergency Preparedness Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Emergency preparedness plan will be added to the QAPI program and reviewed quarterly to ensure compliance with current regulation requirements. Responsible: Maintenance Director	02/28/2020
E 024	Policies/Procedures-Volunteers and Staffing	E 024		

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E 024 SS=F	Continued From page 2 CFR(s): 483.73(b)(6) [(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 document review and staff interview, the facility failed to include policies and procedures addressing the use of volunteers in an emergency.	E 024	Green House Living for Sheridan will ensure that the facility's Emergency Preparedness Plan addresses the use of volunteers in an emergency and/or other emergency staffing. The Administrator and Maintenance Director met on 1/17/2020 to review and update the facilities policies and procedures regarding the use of volunteer and other emergency staffing during an emergency.	01/31/2020

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E 024	Continued From page 3 The findings were: Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that no policies and procedures were available that addressed the use of volunteers in an emergency, or other emergency staffing strategies. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement.	E 024	All Emergency Preparedness Policies & Procedure binders will be updated with the newest emergency preparedness plan which will include this information and the Maintenance Director will educate staff regarding any additions or changes that were made to the plan. The Maintenance Director will report on any updates or additions to the Emergency Preparedness Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Emergency preparedness plan will be added to the QAPI program and reviewed quarterly to ensure compliance with current regulation requirements. Responsible: Maintenance Director	
E 026 SS=F	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	E 026		

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E 026	Continued From page 4 at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to include policies and procedures addressing the role of the facility under waiver declared in an emergency. The findings were: Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that no policies and procedures were available that addressed the role of the facility under a waiver declared by the HHS Secretary in the provision of care and treatment at an alternate care site. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement.	E 026	Green House Living for Sheridan will ensure that the facility's Emergency Preparedness Plan addresses the role of the facility under a waiver declared by the HHS secretary in the provision of care and treatment at an alternate care site. The Administrator and Maintenance Director will review and update the facilities policies and procedures regarding the role of the facility under a waiver declared by the HHS secretary in the provision of care and treatment at an alternate care site. The Interdisciplinary Team will meet to review the facility's emergency preparedness plan to review the policies and procedures regarding the role of the facility under a waiver declared by the HHS secretary in the provision of care and treatment at an alternate care site and make any changes or updates as necessary. All Emergency Preparedness Policies & Procedure binders will be updated with the newest emergency preparedness plan which will include this information and the Maintenance Director will educate staff regarding any additions or changes that were made to the plan. The Maintenance Director will report on any updates or additions to the Emergency Preparedness Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Emergency preparedness plan will be added to the QAPI program and reviewed quarterly to ensure compliance with current regulation requirements. Responsible: Maintenance Director	02/28/2020
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) [(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).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians	E 030		

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	535064	A. BUILDING _____ B. WING _____	01/16/2020

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E 030	Continued From page 5 (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The	E 030		

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E 030	Continued From page 6 communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs, (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to include all required names and contact information in their Communication Plan. The findings were:	E 030	Green House Living for Sheridan will ensure that the facility's Communication Plan includes all required names and contact information. Reviewing the Communication Plan has been added to the facility's TELS building management software system to ensure continued accuracy of the information it contains.	02.28.2020

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E 030	Continued From page 7 Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that the facility did not have included in its Communication Plan the names and contact information for other LTC facilities or volunteers. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement.	E 030	The interdisciplinary team will meet to review the Communication Plan and ensure its accuracy and inclusion of all required names and contact information. All Emergency Preparedness Policies & Procedure binders will be updated with the newest Communication Plan and the Maintenance Director will educate staff regarding the Communication Plan. The Maintenance Director will report on any updates or additions to the Communication Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Communication Plan will be added to the QAPI program and reviewed quarterly to ensure accuracy, completion, and compliance with current regulation requirements. Responsible: Maintenance Director	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(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).] 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: (i) Federal, State, tribal, regional, and local	E 031		

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GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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E 031	Continued From page 8 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: Based on document review and staff interview, the facility failed to include all required emergency officials contact information in their Communication Plan. The findings were: Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that the facility did not have included in its Communication Plan contact information for the state licensing and certification agency or the office of the state long-term care ombudsman. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement..	E 031	Green House Living for Sheridan will ensure that the facility's Communication Plan includes all required emergency officials contact information. Reviewing the Communication Plan has been added to the facility's TELS building management software system to ensure continued accuracy of the information it contains. The interdisciplinary team met to review the Communication Plan and ensure its accuracy and inclusion of all required emergency officials contact information. All Emergency Preparedness Policies & Procedure binders will be updated with the newest Communication Plan and the Maintenance Director will educate staff regarding the Communication Plan. The Maintenance Director will report on any updates or additions to the Communication Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Communication Plan will be added to the QAPI program and reviewed quarterly to ensure accuracy, completion, and compliance with current regulation requirements. Responsible: Maintenance Director	02-28-2020
E 032 SS=F	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(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).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E 032		

PRINTED: 01/27/2020
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	01/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 032	Continued From page 9 (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide primary and alternate means of communication in their Communication Plan. The findings were: Document review of the Emergency Preparedness Plan on 01/15/2020 at 2:45 PM revealed that the facility did not have included in its Communication Plan a primary and alternate means of communication with their staff and with emergency officials. Interview with the facility administrator acknowledged the deficiency, and revealed they were aware of the requirement.	E 032	Green House Living for Sheridan will ensure that the facility's Communication Plan outlines their primary and alternate means of communication. The interdisciplinary team will meet to review the Communication Plan and ensure it addresses primary and alternate means of communication. All Emergency Preparedness Policies & Procedure binders will be updated with the newest Communication Plan and the Maintenance Director will educate staff regarding the Communication Plan. The Maintenance Director will report on any updates or additions to the Communication Plan at the monthly safety meeting as necessary. Monitoring of the review and updating of the facility's Communication Plan will be added to the QAPI program and reviewed quarterly to ensure accuracy, completion, and compliance with current regulation requirements. Responsible: Maintenance Director	02.28.2020