STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 11/22/2022. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced	E 009		12/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/12/2022

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.

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E 009	Continued From page 1 by: Based on document review and staff interview, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials in accordance with §483.73(a)(4). Failure to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials could result in an inadequate response with emergency preparedness officials in the event of an emergency. The deficiency had the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 11:10 AM revealed that the facility's emergency preparedness plan did not include a process for cooperation and collaboration with emergency preparedness officials. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	E 009	Tag 0009-483-73(a)(4) Local, State, Tribal Collaboration Process The Preparedness Plan will be updated to include a process for coooperation and collaboration with local, regional, State or Federal emergency preparedness plans. Any changes made to the Preparedness Plan will be conveyed to the local authorities by the Maintenance Director in writing. And any suggestions that are pertinent to Green House Living for Sheridan will be discussed. All elders are affected by the Emergency Preparedness plan. The Maintenance Director will contact Local coalitions and will attend any meeting that addresses Emergency plans. These agencies may be the local Fire Marshal, Sheriff' or Police Department. These meetings will be documented. Health Department meetings take place every Thursday fo each month. All changes to the preparedness plan will be communicated to the facilites employess and trained. The Emergency Preparedness binder will be updated to include training. Preparedness Plan will begin its update by 12/9/22. To be completed when Local, State, Federal Authorities have had a time to collaborate. All updates will be available for staff and	

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E 009	Continued From page 2	E 009	educated, and documented. To be reviewed at each QA as they change, addendumized, or altered. Director of Maintenance to review these changes with QA and QAPI and it progress monthly and Quarterly.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.	E 039		12/9/22

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E 039	Continued From page 3 (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years,	E 039		

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E 039	Continued From page 4 opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a	E 039		

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E 039	Continued From page 5 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant	E 039		

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E 039	Continued From page 6 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 7 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 8 (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.	E 039		

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E 039	Continued From page 9 *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		

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E 039	Continued From page 10 *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	E 039	Tag 0039-483.73(d)(2) EP Testing	

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E 039	Continued From page 11 the facility failed to conduct exercises to test the emergency plan in accordance with §483.73(d)(2). Failure to conduct exercises to test the emergency plan could result in an inadequate response from staff in the event of an emergency. The deficiency had the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 11:10 AM revealed that the facility had not conducted any exercises, full scale or table top, to test the emergency plan. Interview with staff revealed that the plan had been activated during the year due to a flooding incident in one of the cottages however, no documentation was available to demonstrate the plan had been activated. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	E 039	Requirements (Emergency Preparedness) The policy for Emergency Preparedness will be added that Green House Living for Sheridan will conduct exercises to test the Emergency Plan for our Elders and staff. This plan to include the following: 1. Staff's roles 2. contact list of Emergency personnel, staff listing of phone numbers. 3. location and procedure of evacuation. 4. safety of Medication translocation. 5. Each chart is available with important information in chart. 6. Evacuation location for each circumstance. 7. whom to evacuate first. 8. triage area. 9 command center 10. blankets, go to bags/totes. This is a minimum of changes to policy. A table top discuss will occur regarding these changes. Green House living for Sheridan had on 2/20/2022 experienced a flood in Founders cottage. This was a ful-scale emergency at the location. All staff were notified immediately and Elders were evacuated to Watt cottage. There were no incidents, injuries or not deaths. All elders did not miss a meal, no medication errors or missed. Fall families were notified including the Medical Director. Also, the Board of Directors were notified. Local Authorities, staff were notified and a part of the emergency. This event occured without incident. A review of area's occurred with outcome	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 12	E 039	of positive outcome. An annual review of Emergency Preparedness will occur and be documented. Future drills will continue including table top meetings and recorded. QA and QAPI to review monthly and annually.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing	E 041		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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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E 041	Continued From page 13 structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are	E 041		

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E 041	Continued From page 14 incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect, test, and maintain the Essential Electrical System (EES) in accordance with §483.73(e)(2). Failure to inspect, test, and maintain the EES could result in a malfunction of the EES in the event of a power outage. The deficiency has the potential to impact all residents, staff, and visitors.	E 041	Tag 0041-483.73(e) Hospital CAH and LTC Emergency Power The Maintenance Director has contacted Montana-Dakota Utilities to ensure that the natural gas generator will function correctly in an Emergency. This was performed on 12/5/2022 If a power outage occurs, the generator	

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E 041	Continued From page 15 The findings were: Document review on 11/22/2022 starting at 11:10 AM revealed that the facility did not have proof of low probability of interruption of their natural gas source for their emergency generator. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	E 041	needs to be running to ensure the Elders have safetly needs met. The generator will be inspected by the Maintenance Director weekly. These inspections will be documented. This inspection will consist of the minimum of review Battery, oil, under load, belts, exhaust and any mechanical concerns. The Maintenance Director will contact MDU annually to ensure that Green House Living for Sheridan will have fuel to the generator if there is a natural disaster. Documentation from MDU will be kept on file. MDU has provided documentation to the location on December 6th, 2022. All documentation from MDU has been filed with Maintenance Director. This will be reviewed at the QA and QAPI for compliance for one month at QA and at QAPI quarterly. Compliant 12/8/22	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 11/22/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association.	K 000		

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K 000	Continued From page 16 The facility was a fully sprinklered, single-story building of Type V (III) construction 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 48 certified Medicare and Medicaid beds with a census of 28 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 11/22/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type V (III) construction 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 48 certified Medicare and Medicaid beds with a census of 28 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 11/22/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the	K 000		

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K 000	Continued From page 17 applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type V (III) construction 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 48 certified Medicare and Medicaid beds with a census of 28 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 11/22/2022. Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in this section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type V (III) construction 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 48 certified Medicare and Medicaid beds with a census of 28 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		12/10/22

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K 345	Continued From page 18 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 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that no documentation was available to demonstrate that the fire alarm system batteries had been inspected and load voltage tested in the last twelve (12) months. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	K 345	Tag 0345-NFPA 101 Fire Alarm System-Testing and Maintenance The fire alarm smoke detector system will be inspected annually to State standards. This inspection will be performed by a third-party vendor. Each smoke detector should be working in conjunction with the fire alarm and the alarm lights. Resident that could be affected by this deficiency are all. The fire alarm system is working correctly to ensure the facility remains safe. The Maintenance Director is required to schedule a smoke detector test with a third-party vendor. These inspections will be scheduled annually. The Maintenance Director will review all inspection documentation quarterly at QA to ensure when the next inspection wil be performed. And report to the Quality Assurance Committee. The last completed alarm inspection was	

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K 345	Continued From page 19 Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the annual testing of the fire alarm system had been inspected and tested as required. At the time of the survey no documentation was available to show that the fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, or smoke detectors had been tested in the last twelve (12) months. Fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, and smoke detectors shall be tested annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(1), Table 14.4.5(20), Table 14.4.5(15)(f), 14.4.5(15)(e), Table 14.4.5(15)(h), 2012 NFPA 90A 4.4.1	K 345	September 1, 2022. This inspection was performed. The next scheduled alarm inspection will be in August, 2022. All files have been documented from previous inspections. Maitenance Director will report to QA and QAPI for three quarters. Compliant 12/10/2022	
K 345 SS=F	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	K 345		12/10/22

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K 345	Continued From page 20 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 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that no documentation was available to demonstrate that the fire alarm system batteries had been inspected and load voltage tested in the last twelve (12) months. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	ag 0345-NFPA 101 Fire Alarm System-Testing and Maintenance The fire alarm smoke detector system will be inspected annually to State standards. This inspection will be performed by a third-party vendor. Each smoke detector should be working in conjunction with the fire alarm and the alarm lights. Resident that could be affected by this deficiency are all. The fire alarm system is working correctly to ensure the facility remains safe. The Maintenance Director is required to schedule a smoke detector test with a third-party vendor. These inspections will be scheduled annually. The Maintenance Director will review all inspection documentation quarterly at QA to ensure when the next inspection wil be performed. And report to the Quality Assurance Committee. The last completed alarm inspection was September 1, 2022. This inspection was performed. The next scheduled alarm inspection will be in August, 2022. All files have been documented from previous	

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K 345	Continued From page 21 Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the annual testing of the fire alarm system had been inspected and tested as required. At the time of the survey no documentation was available to show that the fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, or smoke detectors had been tested in the last twelve (12) months. Fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, and smoke detectors shall be tested annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(1), Table 14.4.5(20), Table 14.4.5(15)(f), 14.4.5(15)(e), Table 14.4.5(15)(h), 2012 NFPA 90A 4.4.1	K 345	inspections. Maitnenace Director will report to QA and QAPI for three quarters. Compliant 12/10/2022	
K 345 SS=F	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	K 345		12/10/22

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K 345	Continued From page 22 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 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that no documentation was available to demonstrate that the fire alarm system batteries had been inspected and load voltage tested in the last twelve (12) months. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the annual testing of the fire alarm system had been inspected and tested as required. At the	K 345	ag 0345-NFPA 101 Fire Alarm System-Testing and Maintenance The fire alarm smoke detector system will be inspected annually to State standards. This inspection will be performed by a third-party vendor. Each smoke detector should be working in conjunction with the fire alarm and the alarm lights. Resident that could be affected by this deficiency are all. The fire alarm system is working correctly to ensure the facility remains safe. The Maintenance Director is required to schedule a smoke detector test with a third-party vendor. These inspections will be scheduled annually with Rapid Fire is our vendor. The Maintenance Director will review all inspection documentation quarterly at QA to ensure when the next inspection will be performed. And report to the Quality Assurance Committee. The last completed alarm inspection was September 1, 2022. This inspection was performed. The next scheduled alarm inspection will be in August, 2022. All files have been documented from previous inspections. Maintenance Director will report to QA and	

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K 345	Continued From page 23 time of the survey no documentation was available to show that the fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, or smoke detectors had been tested in the last twelve (12) months. Fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, and smoke detectors shall be tested annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(1), Table 14.4.5(20), Table 14.4.5(15)(f), 14.4.5(15)(e), Table 14.4.5(15)(h), 2012 NFPA 90A 4.4.1	K 345	QAPI for three quarters. Compliant 12/10/2022	
K 345 SS=F	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	K 345	ag 0345-NFPA 101 Fire Alarm System-Testing and Maintenance	12/10/22

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	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 24 alarm system in accordance with the 2012 NFPA 101, Life Safety Code, and 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system which could result in injury or death in the event of a fire. The deficiencies affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that no documentation was available to demonstrate that the fire alarm system batteries had been inspected and load voltage tested in the last twelve (12) months. Fire alarm system batteries shall be inspected and load voltage tested once every six (6) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the annual testing of the fire alarm system had been inspected and tested as required. At the time of the survey no documentation was available to show that the fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, or smoke	K 345	The fire alarm smoke detector system will be inspected annually to State standards. This inspection will be performed by a third-party vendor. Each smoke detector should be working in conjunction with the fire alarm and the alarm lights. Resident that could be affected by this deficiency are all. The fire alarm system is working correctly to ensure the facility remains safe. The Maintenance Director is required to schedule a smoke detector test with a third-party vendor. These inspections will be scheduled annually with Vendor The Maintenance Director will review all inspection documentation quarterly at QA to ensure when the next inspection wil be performed. And report to the Quality Assurance Committee. The last completed alarm inspection was September 1, 2022. This inspection was performed by Vendor. The next scheduled alarm inspection will be in August, 2022. All files have been documented from previous inspections. Maitnenace Director will report to QA and QAPI for three quarters. Compliant 12/10/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 25 detectors had been tested in the last twelve (12) months. Fire alarm annunciation panels, notification devices, manual pull stations, heat detectors, smoke dampers, and smoke detectors shall be tested annually. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.3.4.1, 9.6.1.3; 2010 NFPA 72 Table 14.4.5(1), Table 14.4.5(20), Table 14.4.5(15)(f), 14.4.5(15)(e), Table 14.4.5(15)(h), 2012 NFPA 90A 4.4.1	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 353	Continued From page 26 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to properly test and maintain the fire sprinkler system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could impact all patients, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the full flow test for the fire sprinkler dry system had been performed in the previous three (3) years. No documentation was available at the time of the inspection to indicate when the last full flow test of the system had been performed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.2.2 Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353	Tag 0353-NFPA 101 Sprinkler System-Maintenance and Testing The sprinkler fire system must have a full trip system checked every 3 years. The inspection will be performed by a third party inspector. This system inspection will ensure that the sprinkler system does not have any leaks and is functioning as it should. The Maintenance Director has scheduled a system check with Rapid Fired. If the sprinkler system is not working correctly, the sprinklers will not put out a fire if the fire is in the facility. All Elders could be affected by the sprinkler system malfunctioning. A third-party inspector will automatically schedule a full system trip to be performed every 3 years. The inspectors documents will be reviewed by the Maintenance Director annually to ensure the system is up to date. All actions will take place before January 13th. All documents from the inspection will be filed with the Maintenance Department and given provided to QA/QAPI when performed.	
K 353 SS=F		K 353		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 353	Continued From page 27 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the full flow test for the fire sprinkler dry system had been performed in the previous three (3) years. No documentation was available at the time of the inspection to indicate when the last full flow test of the system had been performed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.2.2	K 353	Tag 0353-NFPA 101 Sprinkler System-Maintenance and Testing The sprinkler fire system must have a full trip system check every 3 years. The inspection will be performed by a third-party inspector. This system inspection will ensure that the sprinkler system does not have any leaks and is functioninng as it should. The Maintenance Director has scheduled a system to be inspected. If the sprinkler system is not working correctly, the sprinklers will not put out a fire if the fire is in the facility. All the residents could be affected by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 353	Continued From page 28	K 353	sprinkler system malfunctioning. A third-party insepctor will automatically schedule a full system trip to be performed every 3 years. The inspector's documents will be reviewed by the Maintenance Director annually to ensure the system is up to date. All actions will take place before January 13th. All documentation from the inspection will be filed with the Maintenance Department and given provided to QA/QAPI when performed.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		12/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 29 This REQUIREMENT is not met as evidenced by: Document review on 11/22/22022 starting at 9:50 AM revealed that no evidence was available that the full flow test for the fire sprinkler dry system had been performed in the previous three (3) years. No documentation was available at the time of the inspection to indicate when the last full flow test of the system had been performed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.2.2	K 353	Tag 0353-NFPA 101 Sprinkler System-Maintenance and Testing The sprinkler fire system must have a full trip system check every 3 years. The inspection will be performed by a third-party inspector. This system inspection will ensure that the sprinkler system does not have any leaks and is functioning as it should. The Maintenance Director has scheduled a system to be inspected. If the sprinkler system is not working correctly, the sprinklers will not put out a fire if the fire is in the facility. All the residents could be affected by the sprinkler system malfunctioning. A third-party inspector will automactically schedule a full system trip to be performed every 3 years. The inspector's documents will be reviewed by the Maintenance Director annually to ensure the system is up to date. All actions will take place before January 13th. All documents from the inspection will be filed with the Maintenance Department and given provided to QA/QAPI when performed.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		12/8/22

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K 353	Continued From page 30 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Document review on 11/22/2022 starting at 9:50 AM revealed that no evidence was available that the full flow test for the fire sprinkler dry system had been performed in the previous three (3) years. No documentation was available at the time of the inspection to indicate when the last full flow test of the system had been performed. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.2.2	K 353	Tag 0353-NFPA 101 Sprinkler System-Maintenance and Testing The sprinkler fire system must have a full trip system check every 3 years. The inspection will be performed by a third-party inspector. This system inspection will ensure that the sprinkler system does not have any leaks and is functioning as it should. The Maintenance Director has scheduled a system to be inspected. If the Sprinkler system is not working correctly, the sprinklers will not put out a fire if the fire is in the facility. All the Elders could be affected by the sprinkler system malfunctioning.	

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

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K 353	Continued From page 31	K 353	A third-party inspector will automactically schedule a full system trip to be performed every 3 years. THe inspector's documents will be reviewed by the Maintenance Director annually to ensure the system is up to date. All actions will take place before January 13th. All documents fromt he inspection will be filed with the Maintenance Department and given provided to QA/QAPI when performed.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC	K 521	Tag 0521-NFPA 101 HVAC The Maintenance Director has contacted Vendor on December 5th, 2022 to schedule a fire damper HVAC inspection. The inspector will ensure that all dampers are working correctly.	12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521	Continued From page 32 system, could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the HVAC system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire dampers associated with the HVAC system had not been inspected and tested as required. Documentation review revealed that the last time the fire dampers were inspected and tested was March of 2018. Fire damper shall be inspected and tested once every four (4) years. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.5.2, 9.2.1, 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521	All residents could be affected by this deficiency. Dampers are functional to shut down isolated area's where there might be a fire and smoke to one location. The Maintenance Director will review HVAC documents annually to ensure that all inspections are up to date and present to the QA and QAPI committee annually. The HVAC vendor will be contacted annually regarding upcoming inspections regarding HVAC dampers. All inspections will be recorded and kept on file with the Maintenance Director. HVAC dampers are important in our Buildings to keep smoke and fire contained in one location. Inspections of these dampers will continue and added to the Tels systems to alert inspection are due. Compliant 12/09/2022	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the HVAC system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire dampers associated with the HVAC system had not been inspected and tested as required. Documentation review revealed that the last time the fire dampers were inspected and tested was March of 2018. Fire damper shall be inspected and tested once every four (4) years. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.5.2, 9.2.1, 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521	ag 0521-NFPA 101 HVAC The Maintenance Director has contacted Powder Vendor on December 5th, 2022 to schedule a fire damper HVAC inspection. The inspector will ensure that all dampers are working correctly. All residents could be affected by this deficiency. Dampers are functional to shut down isolated area's where there might be a fire and smoke to one location. The Maintenance Director will review HVAC documents annually to ensure that all inspections are up to date and present to the QA and QAPI committee annually. The HVAC vendor will be contacted annually regarding upcoming inspections regarding HVAC dampers. All inspections will be recorded and kept on file with the Maintenance Director. HVAC dampers are important in our Buildings to keep smoke and fire contained in one location. Inspections of these dampers will continue and added to the Tels systems to alert inspection are due. Compliant 12/09/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the HVAC system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire dampers associated with the HVAC system had not been inspected and tested as required. Documentation review revealed that the last time the fire dampers were inspected and tested was March of 2018. Fire damper shall be inspected and tested once every four (4) years.	K 521	Tag 0521-NFPA 101 HVAC The Maintenance Director has contacted Vendor Heating on December 5th, 2022 to schedule a fire damper HVAC inspection. The inspector will ensure that all dampers are working correctly. All residents could be affected by this deficiency. Dampers are functional to shut down isolated area's where there might be a fire and smoke to one location. The Maintenance Director will review HVAC documents annually to ensure that all inspections are up to date and present to the QA and QAPI committee annually. The HVAC vendor will be contacted annually regarding upcoming inspections regarding HVAC dampers. All inspections will be recorded and kept on file with the Maintenance Director.	12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 521	Continued From page 35 Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.5.2, 9.2.1, 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521	HVAC dampers are important in our Buildings to keep smoke and fire contained in one location. Inspections of these dampers will continue and added to the Tels systems to alert inspection are due. Compliant 12/09/2022	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the HVAC system in accordance with the 2012 NFPA 101, Life Safety Code, and 2012 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain the HVAC system could result in a failure of the system, which could result in injury or death in the event of a fire. The deficiency affected the HVAC system and has the potential to affect all residents, staff, and visitors.	K 521	ag 0521-NFPA 101 HVAC The Maintenance Director has contacted Vendor on December 5th, 2022 to schedule a fire damper HVAC inspection. The inspector will ensure that all dampers are working correctly. All residents could be affected by this deficiency. Dampers are functional to shut down isolated area's where there might be a fire	12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 521	Continued From page 36 The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire dampers associated with the HVAC system had not been inspected and tested as required. Documentation review revealed that the last time the fire dampers were inspected and tested was March of 2018. Fire damper shall be inspected and tested once every four (4) years. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.5.2, 9.2.1, 2012 NFPA 90A 5.4.8.1; 2010 NFPA 80 5.2.1	K 521	and smoke to one location. The Maintenance Director will review HVAC documents annually to ensure that all inspections are up to date and present to the QA and QAPI committee annually. The HVAC vendor will be contacted annually regarding upcoming inspections regarding HVAC dampers. All inspections will be recorded and kept on file with the Maintenance Director. HVAC dampers are important in our Buildings to keep smoke and fire contained in one location. Inspections of these dampers will continue and added to the Tels systems to alert inspection are due. Compliant 12/09/2022	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 761	Continued From page 37 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test fire door assemblies could result in the spread of smoke and fire, which could result in injury or death in the event of a fire. The deficiency affected all fire rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire door assemblies had not been inspected and tested as required. No documentation was available at the time of the survey to demonstrate that the fire door assemblies had been inspected in the past twelve (12) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761	Tag 0761-NFPA 101 Maintenance, Inspection & Testing-Doors The Maintenance Director has been certified to inspect fire doors throughout the facility. The fire doors need to be inspected to ensure the doors are in working condition. The fire doors need to be inspected to ensure that the doors can contain a fire in a certain location. To have a safe building, the fire doors must be functional. All elder could be affected by this deficiency. Quarterly inspections will be performed by the Certified Maintenance Director. All inspections shall be documented and be filed and retained by Maintenance Director. Documents will be reviewed annually and presented to the QAPI committee. The fire doors have been inspected on December 5th, 2022. The next scheduled inspection will be March 1st, 2022. Quarterly Inspections wll be required at the facility. This is in complianance December 5th, 2022.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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(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 761	Continued From page 38 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test fire door assemblies could result in the spread of smoke and fire, which could result in injury or death in the event of a fire. The deficiency affected all fire rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire door assemblies had not been inspected and tested as required. No documentation was available at the time of the survey to demonstrate that the fire door assemblies had been inspected in the past twelve (12) months.	K 761	Tag 0761-NFPA 101 Maintenance, Inspection & Testing-Doors The Maintenance Director has been certified to inspect fire doors throughout the facility. The fire doors need to be inspected to ensure the doors are in working condition. The fire doors need to be inspected to ensure that the doors can contain a fire in a certain location. To have a safe building, the fire doors must be functional. All elder could be affected by this deficiency. Quarterly inspections will be performed by the Certified Maintenance Director. All inspections shall be documented and be filed and retained by Maintenance Director. Documents will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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(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 761	Continued From page 39 Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761	annually and presented to the QAPI committee. The fire doors have been inspected on December 5th, 2022. The next scheduled inspection will be March 1st, 2022. Quarterly Inspections wll be required at the facility. This is in complianance December 5th, 2022.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test fire door assemblies could result in the spread of	K 761	Tag 0761-NFPA 101 Maintenance, Inspection & Testing-Doors The Maintenance Director has been certified to inspect fire doors throughout the facility. The fire doors need to be inspected to ensure the doors are in	12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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

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K 761	Continued From page 40 smoke and fire, which could result in injury or death in the event of a fire. The deficiency affected all fire rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire door assemblies had not been inspected and tested as required. No documentation was available at the time of the survey to demonstrate that the fire door assemblies had been inspected in the past twelve (12) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761	working condition. The fire doors need to be inspected to ensure that the doors can contain a fire in a certain location. To have a safe building, the fire doors must be functional. All elder could be affected by this deficiency. Quarterly inspections will be performed by the Certified Maintenance Director. All inspections shall be documented and be filed and retained by Maintenance Director. Documents will be reviewed annually and presented to the QAPI committee. The fire doors have been inspected on December 5th, 2022. The next scheduled inspection will be March 1st, 2022. Quarterly Inspections wll be required at the facility. This is in compliance December 5th, 2022.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience	K 761		12/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 761	Continued From page 41 that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire door assemblies in accordance with the 2012 NFPA 101, Life Safety Code and 2010 NFPA 80 Standard for Fire Doors and Other Opening Protectives. Failure to properly inspect and test fire door assemblies could result in the spread of smoke and fire, which could result in injury or death in the event of a fire. The deficiency affected all fire rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the fire door assemblies had not been inspected and tested as required. No documentation was available at the time of the survey to demonstrate that the fire door assemblies had been inspected in the past twelve (12) months. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 80 5.2.1, 5.2.3	K 761	Tag 0761-NFPA 101 Maintenance, Inspection & Testing-Doors The Maintenance Director has been certified to inspect fire doors throughout the facility. The fire doors need to be inspected to ensure the doors are in working condition. The fire doors need to be inspected to ensure that the doors can contain a fire in a certain location. To have a safe building, the fire doors must be functional. All elder could be affected by this deficiency. Quarterly inspections will be performed by the Certified Maintenance Director. All inspections shall be documented and be filed and retained by Maintenance Director. Documents will be reviewed annually and presented to the QAPI committee. The fire doors have been inspected on December 5th, 2022. The next scheduled inspection will be March 1st, 2022. Quarterly Inspections wll be required at the facility. This is in complianance December 5th, 2022.	

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

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K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	K 918	Tag 0918-NFPA 101 Electrical	11/30/22

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

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K 918	Continued From page 43 the facility failed to test and maintain the essential electrical system (EES) accordance with the 2012 NFPA 99, Health Care Facilities Code and 2010 NFPA 110 Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in the EES working improperly, which could result in injury or death in the event of a power outage. The deficiency affected the EES and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. Document review revealed that no letter was available from the facility's natural gas provider stating that the probability of interruption is low. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	K 918	System-Essential Electric System The Maintenance Director will perform a full inspection of all the components of the generator when under a load. The Maintenance Director will check the level of Oil and coolant. All hoses, fan belts and mechanical components will be inspected. Ensure that the fuel system is providing fuel. Inspect the exhaust for no blockage. It is important to check the battery system. The battery gravity will be inspected. The air filter will be inspected. The generator needs to be working properly to ensure that the residents have the life essential during an outage. All elders could be affected by an outage. Monthly full inspections will be performed by the Maintnance Director. Monthly inspections will be logged and filed. Quarterly inspections will be performed by a third-party company. All components will be inspected by this vendor. The generator was fully inspected on November 30th, 2022. The next full inspection will be performed by the Maintenance Director before December 31st, 2022. This inspection will continue montlhy for the life of the generator. Attachment from MDU is attached. Monthly documents will be presented to QA committee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 44	K 918		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		11/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREEN HOUSE LIVING FOR SHERIDAN	**2311 SHIRLEY COVE** **SHERIDAN, WY 82801**

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K 918	Continued From page 45 Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) accordance with the 2012 NFPA 99, Health Care Facilities Code and 2010 NFPA 110 Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in the EES working improperly, which could result in injury or death in the event of a power outage. The deficiency affected the EES and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. Document review revealed that no letter was available from the facility's natural gas provider stating that the probability of interruption is low. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	K 918	Tag 0918-NFPA 101 Electrical System-Essential Electric System The Maintenance Director will perform a full inspection of all the components of the generator when under a load. The Maintenance Director will check the level of Oil and coolant. All hoses, fan belts and mechanical components will be inspected. Ensure that the fuel system is providing fuel. Inspect the exhaust for no blockage. It is important to check the battery system. The battery gravity will be inspected. The air filter will be inspected. The generator needs to be working properly to ensure that the residents have the life essential during an outage. All elders could be affected by an outage. Monthly full inspections will be performed by the Maintnance Driector. Monthly inspections will be logged and filed. Quarterly inspections will be performed by a third-party company. All components will be inspected by this vendor. The generator was fully inspected on November 30th, 2022. The next full inspection will be performed by the Maintenance Director before December 31st, 2022. This inspection will continue montlhy for the life of the generator. Attached Document of MDU memorandium attached. Monthly documents will be presented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 46	K 918	QA committee for review.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		11/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**11/22/2022**

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 918	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) accordance with the 2012 NFPA 99, Health Care Facilities Code and 2010 NFPA 110 Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in the EES working improperly, which could result in injury or death in the event of a power outage. The deficiency affected the EES and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. Document review revealed that no letter was available from the facility's natural gas provider stating that the probability of interruption is low. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	K 918	Tag 0918-NFPA 101 Electrical System-Essential Electric System The Maintenance Director will perform a full inspection of all the components of the generator when under a load. The Maintenance Director will check the level of Oil and coolant. All hoses, fan belts and mechanical components will be inspected. Ensure that the fuel system is providing fuel. Inspect the exhaust for no blockage. It is important to check the battery system. The battery gravity will be inspected. The air filter will be inspected. The generator needs to be working properly to ensure that the residents have the life essential during an outage. All elders could be affected by an outage. Monthly full inspections will be performed by the Maintnance Driector. Monthly inspections will be logged and filed. Quarterly inspections will be performed by a third-party company. All components will be inspected by this vendor. The generator was fully inspected on November 30th, 2022. The next full inspection will be performed by the Maintenance Director before December 31st, 2022. This inspection will continue montlhy for the life of the generator. MDU documentation Attached to POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 48	K 918	Monthly documents will be presented to QA committee for review.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		11/30/22

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

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K 918	Continued From page 49 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) accordance with the 2012 NFPA 99, Health Care Facilities Code and 2010 NFPA 110 Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in the EES working improperly, which could result in injury or death in the event of a power outage. The deficiency affected the EES and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 11/22/2022 starting at 9:50 AM revealed that the facility failed to provide proof of low probability of interruption of their natural gas source for their emergency electrical generator. Document review revealed that no letter was available from the facility's natural gas provider stating that the probability of interruption is low. Interview with maintenance personnel at the time of the observation acknowledge the deficiency, but indicated they were unaware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2012 NFPA 110 5.1.4	K 918	Tag 0918-NFPA 101 Electrical System-Essential Electric System The Maintenance Director will perform a full inspection of all the components of the generator when under a load. The Maintenance Director will check the level of Oil and coolant. All hoses, fan belts and mechanical components will be inspected. Ensure that the fuel system is providing fuel. Inspect the exhaust for no blockage. It is important to check the battery system. The battery gravity will be inspected. The air filter will be inspected. The generator needs to be working properly to ensure that the residents have the life essential during an outage. All elders could be affected by an outage. Monthly full inspections will be performed by the Maintenance Director. Monthly inspections will be logged and filed. Quarterly inspections will be performed by a third-party company. All components will be inspected by this vendor. The generator was fully inspected on November 30th, 2022. The next full inspection will be performed by the Maintenance Director before December 31st, 2022. This inspection will continue monthly for the life of the generator. MDU Documentation attached to POC.	

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K 918	Continued From page 50	K 918	Monthly documents will be presented to QA committee for review.	