STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	01/30/2024

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 01/30/2024. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
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. (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	E 039		2/22/24

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

Electronically Signed | 02/20/2024

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 1 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, 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	E 039		

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E 039	Continued From page 2 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 narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to	E 039		

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E 039	Continued From page 3 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 emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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E 039	Continued From page 4 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 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 5 (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. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

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E 039	Continued From page 6 [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. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at	E 039		

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E 039	Continued From page 7 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. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the	E 039		

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E 039	Continued From page 8 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, the facility failed to conduct testing of the Emergency Preparedness Plan (EPP) as required in accordance with §483.73(d)(2). Failure to	E 039	Plan of Correction: Green House Living will conduct a facility-based exercise to test the emergency plan at least annually. In addition, a tabletop exercise will be	

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E 039	Continued From page 9 conduct testing of the EPP could result in inadequate preparedness of staff in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 1:50 PM revealed that the facility did not have documentation available to demonstration that all required testing of the EPP had been conducted in the last twelve (12) months. Documentation was available to demonstrate that a community-based full scale exercise had been conducted, but no additional documentation was available to demonstrate that the facility had conducted a second full scale exercise, table top exercise, or experienced an emergency that required activation of the emergency plan. Interview with administrative staff at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	E 039	completed no later than March 6, 2024. As members of the Local Emergency Planning Committee, Green House Living is dedicated to maintaining and ensuring the safety of our residents and community. Future Plan: Green House Living will maintain continued efforts to ensure drills/exercises are completed annually including unannounced drills. To ensure this deficiency does not occur again, the Safety Committee will review the training and testing requirements within the emergency preparedness plan annually and anytime amendments are made. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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	535054	A. BUILDING **01 - SCOTT BUILDING** B. WING _____	**01/30/2024**

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/30/2024. 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 12 certified Medicare and Medicaid beds with a census of 12 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 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,	K 345	Plan of Correction: Green House Living will conduct all semi-annual testing of the fire alarm system, as well as all quarterly testing of the waterflow alarm devices and	2/22/24

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

Electronically Signed | 02/20/2024

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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K 345	Continued From page 1 National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all semi-annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the inspection and load voltage testing of the fire alarm system batteries had been conducted twice in the last twelve (12) months. Documentation was available to demonstrate that the inspection and load testing of the fire alarm system batteries had been conducted in November of 2023, but no additional documentation was available to demonstrate testing had been conducted in the previous six (6) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all	K 345	supervisory signal devices, and monthly activation tests of the fire alarm system. Our vendor has been notified and will return to complete the semi-annual testing for 2024 in May and then again in November. We have also created a checklist to activate the fire alarm each month and accurately document whether it is for a simulation or for the monthly test. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly fire alarm tests to ensure that a document or appointment is not missed. We will also maintain a checklist for quarterly testing of the waterflow alarm devices and supervisory signal devices. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 2 quarterly testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the quarterly testing of the waterflow alarm devices and supervisory signal devices had been conducted four (4) times in the last twelve (12) months. Documentation was available to demonstrate that testing of the waterflow alarm devices and supervisory signal devices had been conducted in November and July of 2022, and March of 2023, but no additional documentation was available to demonstrate testing had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 13.2.6.1, 5.3.2; 2011 NFPA 25 Table 5.1.1.2 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted during the last twelve (12) months. Documentation was available to demonstrate that the fire alarm was being activated during some of the fire drills, but no additional documentation was available to demonstrate it was being activated, during the months that fire drills were simulated without	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01 - SCOTT BUILDING** B. WING _____	**01/30/2024**

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

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K 345	Continued From page 3 activation or during the months that fire drills weren't being conducted. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 345		
K 353 SS=F	Ref: 2010 NFPA 72 Table 14.4.5(24) 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 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 353	Plan of Correction: Green House Living will conduct all quarterly testing of the fire	2/22/24

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K 353	Continued From page 4 sprinkler system in accordance with the 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 malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform quarterly testing of the fire sprinkler system. No documentation was available at the time of the survey to demonstrate that the priming water and low air alarm were tested all four (4) quarters of the last twelve (12) months. Documentation was available to show that the dry system was tested in November and July of 2022, and March of 2023, but no additional testing documentation was available. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.1, 13.4.4.2.6 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was	K 353	sprinkler system in accordance with the 2011 NFPA 25. We will also complete the required quarterly testing of the priming water and low air alarm. Green House Living will also conduct the annual test of the sprinkler system backflow preventer. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly sprinkler tests, priming water and low air alarm tests, and sprinkler system backflow preventer to ensure that a document or appointment is not missed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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K 353	Continued From page 5 available at the time of the survey to demonstrate that the annual testing of the fire sprinkler system backflow preventer had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 353		
K 761 SS=F	Ref: 2011 NFPA 25 13.6.2.1 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 test and maintain egress doors and fire-rated doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010	K 761	Plan of Correction: Green House Living will conduct an inspection and testing of all egress doors and fire-rated doors. Our facility director will complete the CMS Life	2/22/24

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K 761	Continued From page 6 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain egress doors and fire-rated doors could result in a delay or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all egress and fire rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of egress and fire-rated doors. No documentation was available at the time of the survey to demonstrate that the annual inspection of door assemblies that swing in the direction of egress travel, or fire-rated door assemblies, had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	Safety Code training and verify the safety of all doors in accordance with NFPA 80. Future Plan: Green House Living will conduct and maintain an annual test of all egress and fire-rated doors and store information properly. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. The facility director will also periodically check these doors in order to maintain complete accuracy. Responsible Party: Facility Director	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		2/22/24

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K 914	Continued From page 7 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain non-hospital grade receptacles in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain non-hospital grade receptacles could result in a failure or malfunction of the receptacles, resulting in injury or death. The deficiency affected all non-hospital grade receptacles in patient care areas, and had the potential to affect all residents, staff, and visitors in those spaces. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of non-hospital grade receptacles in patient care areas. No documentation was available at the time of the	K 914	Plan of Correction: Green House Living completed the annual test of non-hospital grade electrical receptacles on February 13, 2024. The test was completed by our vendor, and determined to be safe. Future Plan: Green House Living will continue to conduct an annual test of non-hospital grade electrical receptacles and log proper documentation as needed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Facilities Director	

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K 914	Continued From page 8 survey to demonstrate that the annual inspection and testing of the non-hospital grade receptacles in patient care areas had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 914		
K 918 SS=F	Ref: 2012 NFPA 99 6.3.4.1, 6.3.3.2 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	K 918		2/22/24

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K 918	Continued From page 9 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, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors. The findings were: Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the monthly specific gravity testing of the emergency generator batteries. No documentation was available at the time of the survey to demonstrate that the monthly specific gravity testing of the emergency generator batteries had been conducted at all in the last twelve (12) months.	K 918	Plan of Correction: Green House Living will conduct a 4 hour generator test under load, and complete a monthly specific gravity test of the emergency generator. Future Plan: Green House Living will maintain a 36-month test of the generator under load, for a minimum of 4 hours. Green House will also maintain a monthly log of the specific gravity of the emergency battery within the generator. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director	

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K 918	Continued From page 10 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.3.7.1 Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the four (4) hour test of the EES. No documentation was available at the time of the survey to demonstrate that the four (4) hour continuous load test of the EES had been conducted in the last 36 (thirty-six) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	K 918		

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/30/2024. 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 12 certified Medicare and Medicaid beds with a census of 5 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 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,	K 345	Plan of Correction: Green House Living will conduct all semi-annual testing of the fire alarm system, as well as all quarterly testing of the waterflow alarm devices and	2/22/24

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

Electronically Signed | 02/20/2024

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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K 345	Continued From page 1 National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all semi-annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the inspection and load voltage testing of the fire alarm system batteries had been conducted twice in the last twelve (12) months. Documentation was available to demonstrate that the inspection and load testing of the fire alarm system batteries had been conducted in November of 2023, but no additional documentation was available to demonstrate testing had been conducted in the previous six (6) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all	K 345	supervisory signal devices, and monthly activation tests of the fire alarm system. Our vendor has been notified and will return to complete the semi-annual testing for 2024 in May and then again in November. We have also created a checklist to activate the fire alarm each month and accurately document whether it is for a simulation or for the monthly test. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly fire alarm tests to ensure that a document or appointment is not missed. We will also maintain a checklist for quarterly testing of the waterflow alarm devices and supervisory signal devices. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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K 345	Continued From page 2 quarterly testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the quarterly testing of the waterflow alarm devices and supervisory signal devices had been conducted four (4) times in the last twelve (12) months. Documentation was available to demonstrate that testing of the waterflow alarm devices and supervisory signal devices had been conducted in November and July of 2022, and March of 2023, but no additional documentation was available to demonstrate testing had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 13.2.6.1, 5.3.2; 2011 NFPA 25 Table 5.1.1.2 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted during the last twelve (12) months. Documentation was available to demonstrate that the fire alarm was being activated during some of the fire drills, but no documentation was available to demonstrate it was being activated, during the months that fire drills were simulated without activation or during	K 345		

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K 345	Continued From page 3 the months that fire drills weren't being conducted. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 345		
K 353 SS=F	Ref: 2010 NFPA 72 Table 14.4.5(24) 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 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 353	Plan of Correction: Green House Living will conduct all quarterly testing of the fire	2/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **02 - WATT BUILDING** B. WING _____	**01/30/2024**

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 4 sprinkler system in accordance with the 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 malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform quarterly testing of the fire sprinkler system. No documentation was available at the time of the survey to demonstrate that the priming water and low air alarm were tested all four (4) quarters of the last twelve (12) months. Documentation was available to show that the dry system was tested in November and July of 2022, and March of 2023, but no additional testing documentation was available. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.1, 13.4.4.2.6 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was	K 353	sprinkler system in accordance with the 2011 NFPA 25. We will also complete the required quarterly testing of the priming water and low air alarm. Green House Living will also conduct the annual test of the sprinkler system backflow preventer. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly sprinkler tests, priming water and low air alarm tests, and sprinkler system backflow preventer to ensure that a document or appointment is not missed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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	535054	A. BUILDING 02 - WATT BUILDING B. WING _____	01/30/2024

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K 353	Continued From page 5 available at the time of the survey to demonstrate that the annual testing of the fire sprinkler system backflow preventer had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 353		
K 761 SS=F	Ref: 2011 NFPA 25 13.6.2.1 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 test and maintain egress doors and fire-rated doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010	K 761	Plan of Correction: Green House Living will conduct an inspection and testing of all egress doors and fire-rated doors. Our facility director will complete the CMS Life	2/22/24

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K 761	Continued From page 6 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain egress doors and fire-rated doors could result in a delay or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all egress and fire-rated doors, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of egress and fire-rated doors. No documentation was available at the time of the survey to demonstrate that the annual inspection of door assemblies that swing in the direction of egress travel, or fire-rated door assemblies, had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	Safety Code training and verify the safety of all doors in accordance with NFPA 80. Future Plan: Green House Living will conduct and maintain an annual test of all egress and fire-rated doors and store information properly. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. The facility director will also periodically check these doors in order to maintain complete accuracy. Responsible Party: Facility Director	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		2/22/24

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K 914	Continued From page 7 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain non-hospital grade receptacles in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain non-hospital grade receptacles could result in a failure or malfunction of the receptacles, resulting in injury or death. The deficiency affected all non-hospital grade receptacles in patient care areas, and had the potential to affect all residents, staff, and visitors in those spaces. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of non-hospital grade receptacles in patient care areas. No documentation was available at the time of the	K 914	Plan of Correction: Green House Living completed the annual test of non-hospital grade electrical receptacles on February 13, 2024. The test was completed by our vendor, and determined to be safe. Future Plan: Green House Living will continue to conduct an annual test of non-hospital grade electrical receptacles and log proper documentation as needed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Facilities Director	

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K 914	Continued From page 8 survey to demonstrate that the annual inspection and testing of the non-hospital grade receptacles in patient care areas had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.3.4.1, 6.3.3.2	K 914		
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	K 918		2/22/24

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K 918	Continued From page 9 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, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors. The findings were: Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the monthly specific gravity testing of the emergency generator batteries. No documentation was available at the time of the survey to demonstrate that the monthly specific gravity testing of the emergency generator batteries had been conducted in the last twelve (12) months.	K 918	Plan of Correction: Green House Living will conduct a 4 hour generator test under load, and complete a monthly specific gravity test of the emergency generator. Future Plan: Green House Living will maintain a 36-month test of the generator under load, for a minimum of 4 hours. Green House will also maintain a monthly log of the specific gravity of the emergency battery within the generator. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director	

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K 918	Continued From page 10 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.3.7.1 Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the four (4) hour test of the EES. No documentation was available at the time of the survey to demonstrate that the four (4) hour continuous load test of the EES had been conducted in the last 36 (thirty-six) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of	K 920		2/22/24

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K 920	Continued From page 11 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize power strips could result in Patient Care Related Electrical Equipment (PCREE) working improperly, resulting in injury or death in the event of a malfunction. The deficiency affected two (2) of twelve (12) resident rooms and could potentially affect the residents of those rooms. The findings were: Observation on 01/30/2024 starting at 11:35 AM revealed power strips located in patient care areas while PCREE was present. Observation of resident rooms 211 and 209 revealed power strips in the resident care areas while concentrators and cpap machines were present. Power strips shall not be located in the resident	K 920	Plan of Correction: Green House Living has removed power strips in the patient care area and ensured that no life-saving technologies are plugged into the power strips that remain. Specifically, in two rooms the power strips were removed. Future Plan: Green House Living will ensure that we limit the use of power strips in patient care areas and ensure that there are no life-saving technologies (i.e. oxygen concentrators) plugged into the remaining power strips. The facilities director will also complete a weekly check of this deficiency to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director, Safety Committee	

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K 920	Continued From page 12 care area when PCREE is present. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920		

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	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	**01/30/2024**

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/30/2024. 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 12 certified Medicare and Medicaid beds with a census of 11 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 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,	K 345	Plan of Correction: Green House Living will conduct all semi-annual testing of the fire alarm system, as well as all quarterly testing of the waterflow alarm devices and	2/22/24

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

Electronically Signed | 02/20/2024

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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K 345	Continued From page 1 National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all semi-annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the inspection and load voltage testing of the fire alarm system batteries had been conducted twice in the last twelve (12) months. Documentation was available to demonstrate that the inspection and load testing of the fire alarm system batteries had been conducted in November of 2023, but no additional documentation was available to demonstrate testing had been conducted in the previous six (6) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all	K 345	supervisory signal devices, and monthly activation tests of the fire alarm system. Our vendor has been notified and will return to complete the semi-annual testing for 2024 in May and then again in November. We have also created a checklist to activate the fire alarm each month and accurately document whether it is for a simulation or for the monthly test. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly fire alarm tests to ensure that a document or appointment is not missed. We will also maintain a checklist for quarterly testing of the waterflow alarm devices and supervisory signal devices. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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

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K 345	Continued From page 2 quarterly testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the quarterly testing of the waterflow alarm devices and supervisory signal devices had been conducted four (4) times in the last twelve (12) months. Documentation was available to demonstrate that testing of the waterflow alarm devices and supervisory signal devices had been conducted in November and July of 2022, and March of 2023, but no additional documentation was available to demonstrate testing had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 13.2.6.1, 5.3.2; 2011 NFPA 25 Table 5.1.1.2 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted during the last twelve (12) months. Documentation was available to demonstrate that the fire alarm was being activated during some of the fire drills, but no documentation was available to demonstrate it was being activated during the months that fire drills were simulated without activation, or during	K 345		

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	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	**01/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 3 the months that fire drills weren't being conducted. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24)	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 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	K 353	Plan of Correction: Green House Living will conduct all quarterly testing of the fire	2/22/24

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K 353	Continued From page 4 sprinkler system in accordance with the 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 malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform quarterly testing of the fire sprinkler system. No documentation was available at the time of the survey to demonstrate that the priming water and low air alarm were tested all four (4) quarters of the last twelve (12) months. Documentation was available to show that the dry system was tested in November and July of 2022, and March of 2023, but no additional testing documentation was available. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.1, 13.4.4.2.6 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was	K 353	sprinkler system in accordance with the 2011 NFPA 25. We will also complete the required quarterly testing of the priming water and low air alarm. Green House Living will also conduct the annual test of the sprinkler system backflow preventer. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly sprinkler tests, priming water and low air alarm tests, and sprinkler system backflow preventer to ensure that a document or appointment is not missed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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K 353	Continued From page 5 available at the time of the survey to demonstrate that the annual testing of the fire sprinkler system backflow preventer had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 353		
K 761 SS=F	Ref: 2011 NFPA 25 13.6.2.1 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 test and maintain egress doors and fire-rated doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010	K 761	Plan of Correction: Green House Living will conduct an inspection and testing of all egress doors and fire-rated doors. Our facility director will complete the CMS Life	2/22/24

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K 761	Continued From page 6 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain egress doors and fire-rated doors could result in a delay or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all egress and fire-rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of egress and fire-rated doors. No documentation was available at the time of the survey to demonstrate that the annual inspection of door assemblies that swing in the direction of egress travel or fire-rated door assemblies, had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	Safety Code training and verify the safety of all doors in accordance with NFPA 80. Future Plan: Green House Living will conduct and maintain an annual test of all egress and fire-rated doors and store information properly. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. The facility director will also periodically check these doors in order to maintain complete accuracy. Responsible Party: Facility Director	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		2/22/24

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K 914	Continued From page 7 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain non-hospital grade receptacles in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain non-hospital grade receptacles could result in a failure or malfunction of the receptacles, resulting in injury or death. The deficiency affected all non-hospital grade receptacles in patient care areas, and had the potential to affect all residents, staff, and visitors in those spaces. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of non-hospital grade receptacles in patient care areas. No documentation was available at the time of the	K 914	Plan of Correction: Green House Living completed the annual test of non-hospital grade electrical receptacles on February 13, 2024. The test was completed by our vendor, and determined to be safe. Future Plan: Green House Living will continue to conduct an annual test of non-hospital grade electrical receptacles and log proper documentation as needed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Facilities Director	

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K 914	Continued From page 8 survey to demonstrate that the annual inspection and testing of the non-hospital grade receptacles in patient care areas had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 914		
K 918 SS=F	Ref: 2012 NFPA 99 6.3.4.1, 6.3.3.2 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	K 918		2/22/24

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K 918	Continued From page 9 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, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors. The findings were: Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the monthly specific gravity testing of the emergency generator batteries. No documentation was available at the time of the survey to demonstrate that the monthly specific gravity testing of the emergency generator batteries had been conducted at all in the last twelve (12) months.	K 918	Plan of Correction: Green House Living will conduct a 4 hour generator test under load, and complete a monthly specific gravity test of the emergency generator. Future Plan: Green House Living will maintain a 36-month test of the generator under load, for a minimum of 4 hours. Green House will also maintain a monthly log of the specific gravity of the emergency battery within the generator. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director	

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K 918	Continued From page 10 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.3.7.1 Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the four (4) hour test of the EES. No documentation was available at the time of the survey to demonstrate that the four (4) hour continuous load test of the EES had been conducted in the last 36 (thirty-six) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		2/22/24

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K 923	Continued From page 11 within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders in accordance with 2012 NFPA 99 Health Care Facilities Code. Failure to properly store oxygen cylinders could result in damage to the cylinders, resulting in a release of oxygen. The deficiency affected the oxygen storage room, and had the potential to affect all residents, staff, and visitors.	K 923	Plan of Correction: Green House Living has obtained an extra rack from our Oxygen supplier to store the full tanks that were located on the floor of the storage room. Therefore, no more oxygen tanks are stored outside of the rack. Future Plan: Green House Living will	

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K 923	Continued From page 12 The findings were: Observation on 01/30/2023 at 12:30 PM revealed that the facility failed to properly store oxygen cylinders. Observation of the oxygen storage room revealed four (4) E tank cylinders that were not properly chained or supported in a cylinder stand or cart. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 11.6.2.3(11)	K 923	maintain the necessary number of racks to keep these tanks off the floor in agreement with our oxygen vendor. This will be checked my the Facility Director on a weekly basis and maintain the necessary equipment in order to not have this deficiency going forward. Responsible Party: Facility Director	

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	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	**01/30/2024**

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K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 01/30/2024. 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 12 certified Medicare and Medicaid beds with a census of 10 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 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,	K 345	Plan of Correction: Green House Living will conduct all semi-annual testing of the fire alarm system, as well as all quarterly testing of the waterflow alarm devices and	2/22/24

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

Electronically Signed | 02/20/2024

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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K 345	Continued From page 1 National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm system could result in a failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire alarm system, and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all semi-annual testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the inspection and load voltage testing of the fire alarm system batteries had been conducted twice in the last twelve (12) months. Documentation was available to demonstrate that the inspection and load testing of the fire alarm system batteries had been conducted in November of 2023, but no additional documentation was available to demonstrate testing had been conducted in the previous six (6) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.3.1(3)(d), Table 14.4.5(6)(3) Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all	K 345	supervisory signal devices, and monthly activation tests of the fire alarm system. Our vendor has been notified and will return to complete the semi-annual testing for 2024 in May and then again in November. We have also created a checklist to activate the fire alarm each month and accurately document whether it is for a simulation or for the monthly test. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly fire alarm tests to ensure that a document or appointment is not missed. We will also maintain a checklist for quarterly testing of the waterflow alarm devices and supervisory signal devices. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	**01/30/2024**

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K 345	Continued From page 2 quarterly testing of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the quarterly testing of the waterflow alarm devices and supervisory signal devices had been conducted four (4) times in the last twelve (12) months. Documentation was available to demonstrate that testing of the waterflow alarm devices and supervisory signal devices had been conducted in November and July of 2022, and March of 2023, but no additional documentation was available to demonstrate testing had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 72 13.2.6.1, 5.3.2; 2011 NFPA 25 Table 5.1.1.2 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted during the last twelve (12) months. Documentation was available to demonstrate that the fire alarm was being activated during some of the fire drills, but no documentation was available to demonstrate it was being activated during the months that fire drills were simulated without activation, or during	K 345		

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K 345	Continued From page 3 the months that fire drills weren't being conducted. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency.	K 345		
K 353 SS=F	Ref: 2010 NFPA 72 Table 14.4.5(24) 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 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 353	Plan of Correction: Green House Living will conduct all quarterly testing of the fire	2/22/24

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K 353	Continued From page 4 sprinkler system in accordance with the 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 malfunction or failure of the system, resulting in injury or death in the event of a fire. The deficiency affected the fire sprinkler system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform quarterly testing of the fire sprinkler system. No documentation was available at the time of the survey to demonstrate that the priming water and low air alarm were tested all four (4) quarters of the last twelve (12) months. Documentation was available to show that the dry system was tested in November and July of 2022, and March of 2023, but no additional testing documentation was available. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.4.4.2.1, 13.4.4.2.6 Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was	K 353	sprinkler system in accordance with the 2011 NFPA 25. We will also complete the required quarterly testing of the priming water and low air alarm. Green House Living will also conduct the annual test of the sprinkler system backflow preventer. Future Plan: Green House Living will maintain a checklist of all annual, semi-annual, and quarterly sprinkler tests, priming water and low air alarm tests, and sprinkler system backflow preventer to ensure that a document or appointment is not missed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Safety Committee, Facility Director	

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K 353	Continued From page 5 available at the time of the survey to demonstrate that the annual testing of the fire sprinkler system backflow preventer had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2011 NFPA 25 13.6.2.1	K 353		
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 test and maintain egress doors and fire-rated doors in accordance with the 2012 NFPA 101, Life Safety Code and 2010	K 761	Plan of Correction: Green House Living will conduct an inspection and testing of all egress doors and fire-rated doors. Our facility director will complete the CMS Life	2/22/24

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K 761	Continued From page 6 NFPA 80, Standard for Fire Doors and Other Opening Protectives. Failure to properly test and maintain egress doors and fire-rated doors could result in a delay or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected all egress and fire-rated doors and has the potential to affect all residents, staff, and visitors. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of egress and fire-rated doors. No documentation was available at the time of the survey to demonstrate that the annual inspection of door assemblies that swing in the direction of egress travel or fire-rated door assemblies had been conducted. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 101 19.7.6, 8.3.3.1, 2010 NFPA 80 5.2.1	K 761	Safety Code training and verify the safety of all doors in accordance with NFPA 80. Future Plan: Green House Living will conduct and maintain an annual test of all egress and fire-rated doors and store information properly. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. The facility director will also periodically check these doors in order to maintain complete accuracy. Responsible Party: Facility Director	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	K 914		2/22/24

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K 914	Continued From page 7 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain non-hospital grade receptacles in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain non-hospital grade receptacles could result in a failure or malfunction of the receptacles, resulting in injury or death. The deficiency affected all non-hospital grade receptacles in patient care areas, and had the potential to affect all residents, staff, and visitors in those spaces. The findings were: Document review on 01/30/2024 starting at 12:45 PM revealed that the facility failed to conduct the annual inspection and testing of non-hospital grade receptacles in patient care areas. No documentation was available at the time of the survey to demonstrate that the annual inspection	K 914	Plan of Correction: Green House Living completed the annual test of non-hospital grade electrical receptacles on February 13, 2024. The test was completed by our vendor, and determined to be safe. Future Plan: Green House Living will continue to conduct an annual test of non-hospital grade electrical receptacles and log proper documentation as needed. This will be organized in a binder with the corresponding deficiency number. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Parties: Facilities Director	

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K 914	Continued From page 8 and testing of the non-hospital grade receptacles in patient care areas had been conducted in the last twelve (12) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 6.3.4.1, 6.3.3.2	K 914		
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	K 918		2/22/24

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K 918	Continued From page 9 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, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities, and 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES and could potentially affect all residents, staff, and visitors. The findings were: Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the monthly specific gravity testing of the emergency generator batteries. No documentation was available at the time of the survey to demonstrate that the monthly specific gravity testing of the emergency generator batteries had been conducted in the last twelve (12) months. Interview with the maintenance director at the	K 918	Plan of Correction: Green House Living will conduct a 4 hour generator test under load, and complete a monthly specific gravity test of the emergency generator. Future Plan: Green House Living will maintain a 36-month test of the generator under load, for a minimum of 4 hours. Green House will also maintain a monthly log of the specific gravity of the emergency battery within the generator. The facilities director will also complete a weekly check of this log book to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director	

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K 918	Continued From page 10 time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.3.7.1 Document review and staff interview on 01/30/2024 starting at 12:45 PM revealed that the facility failed to perform the four (4) hour test of the EES. No documentation was available at the time of the survey to demonstrate that the four (4) hour continuous load test of the EES had been conducted in the last 36 (thirty-six) months. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	K 918		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		2/22/24

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K 920	Continued From page 11 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to utilize power strips in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly utilize power strips could result in Patient Care Related Electrical Equipment (PCREE) working improperly, resulting in injury or death in the event of a malfunction. The deficiency affected one (1) of twelve (12) resident rooms and could potentially affect the resident of those room. The findings were: Observation on 01/30/2024 at 11:55 AM revealed power strips located in patient care areas while PCREE was present. Observation of resident room 404 revealed a power strip in the resident care area with a concentrator plugged directly into it. Power strips shall not be located in the resident care area when PCREE is present.	K 920	Plan of Correction: Green House Living has removed power strips in the patient care area and ensured that no life-saving technologies are plugged into the power strips that remain. Specifically, in two rooms the power strips were removed. Future Plan: Green House Living will ensure that we limit the use of power strips in patient care areas and ensure that there are no life-saving technologies (i.e. oxygen concentrators) plugged into the remaining power strips. The facilities director will also complete a weekly check of this deficiency to ensure the information is consistently accurate and up to date. Responsible Party: Facility Director, Safety Committee	

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K 920	Continued From page 12 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2012 NFPA 99 10.2.3.6, CMS S&C: 14-46-LSC	K 920		