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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	R 03/06/2024

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 revisit survey was conducted by Healthcare Licensing and Surveys on 3/06/2024 for deficiencies identified on 01/30/2024. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.73.	{E 000}		

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

Electronically Signed | 03/22/2024

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.

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 _____	R **03/06/2024**

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 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 03/06/2024 for all previous deficiencies cited on 01/30/2024. 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, 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the	{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 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. This checklist can be found in the State binder with other related information.	4/12/24

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

Electronically Signed | 03/22/2024

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.

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 _____	R **03/06/2024**

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 345}	Continued From page 1 time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted since the initial survey on 01/30/2024. Also, no checklist had been created to document when the fire alarm system is activated each month, as was part of the approved plan of correction. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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}	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	
{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.	{K 353}		4/12/24

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 _____	R **03/06/2024**

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 2 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was 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, and no documentation was available to demonstrate that the annual testing was scheduled to be completed. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated 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}	Plan of Correction: Green House Living will conduct all quarterly testing of the fire 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. Our vendor is scheduled to perform necessary backflow tests on 4 cottages on March 22, 2024. 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	
{K 761} SS=F	Maintenance, Inspection & Testing - Doors	{K 761}		4/12/24

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 _____	R **03/06/2024**

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 761}	Continued From page 3 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 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 had the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/06/2024 starting at 8:15 AM 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	{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 Safety Code training and verify the safety of all doors in accordance with NFPA 80. A checklist will be included in the binder of this inspection. 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	

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 _____	R **03/06/2024**

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 761}	Continued From page 4 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 they were aware 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}	order to maintain complete accuracy. Responsible Party: Facilities Director	
{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}		4/12/24

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 _____	R **03/06/2024**

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 918}	Continued From page 5 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 03/06/2024 starting at 8:45 AM 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 during 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	

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 _____	R **03/06/2024**

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 918}	Continued From page 6 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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 03/06/2024 starting at 8:15 AM 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 they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	{K 918}		

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 _____	R **03/06/2024**

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 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 03/06/2024 for all previous deficiencies cited on 01/30/2024. 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, 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the	{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 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. This checklist can be found in the State binder with other related information.	4/12/24

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

Electronically Signed | 03/22/2024

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.

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 _____	R **03/06/2024**

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 345}	Continued From page 1 time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted since the initial survey on 01/30/2024. Also, no checklist had been created to document when the fire alarm system is activated each month, as was part of the approved plan of correction. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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}	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	
{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.	{K 353}		4/12/24

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 _____	R **03/06/2024**

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 2 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was 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, and no documentation was available to demonstrate that the annual testing was scheduled to be completed. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated 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}	Plan of Correction: Green House Living will conduct all quarterly testing of the fire 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. Our vendor is scheduled to perform necessary backflow tests on 4 cottages on March 22, 2024. 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	
{K 761} SS=F	Maintenance, Inspection & Testing - Doors	{K 761}		4/12/24

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 _____	R **03/06/2024**

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 761}	Continued From page 3 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 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 had the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/06/2024 starting at 8:15 AM 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	{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 Safety Code training and verify the safety of all doors in accordance with NFPA 80. A checklist will be included in the binder of this inspection. 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	

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 _____	R **03/06/2024**

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 761}	Continued From page 4 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 they were aware 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}	order to maintain complete accuracy. Responsible Party: Facilities Director	
{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}		4/12/24

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 _____	R **03/06/2024**

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 918}	Continued From page 5 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 03/06/2024 starting at 8:45 AM 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 during 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	

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 _____	R **03/06/2024**

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 918}	Continued From page 6 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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 03/06/2024 starting at 8:15 AM 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 they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	{K 918}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 03 - WHITNEY BUILDING B. WING _____	R 03/06/2024

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 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 03/06/2024 for all previous deficiencies cited on 01/30/2024. 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, 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the	{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 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. This checklist can be found in the State binder with other related information.	4/12/24

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

Electronically Signed | 03/22/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 345}	Continued From page 1 time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted since the initial survey on 01/30/2024. Also, no checklist had been created to document when the fire alarm system is activated each month, as was part of the approved plan of correction. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24)	{K 345}	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	
{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.	{K 353}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 2 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was 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, and no documentation was available to demonstrate that the annual testing was scheduled to be completed. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated 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}	Plan of Correction: Green House Living will conduct all quarterly testing of the fire 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. Our vendor is scheduled to perform necessary backflow tests on 4 cottages on March 22, 2024. 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	
{K 761} SS=F	Maintenance, Inspection & Testing - Doors	{K 761}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 761}	Continued From page 3 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 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 had the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/06/2024 starting at 8:15 AM 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	{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 Safety Code training and verify the safety of all doors in accordance with NFPA 80. A checklist will be included in the binder of this inspection. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 761}	Continued From page 4 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 they were aware 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}	order to maintain complete accuracy. Responsible Party: Facilities Director	
{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}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 918}	Continued From page 5 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 03/06/2024 starting at 8:45 AM 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 during 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **03 - WHITNEY BUILDING** B. WING _____	R **03/06/2024**

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 918}	Continued From page 6 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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 03/06/2024 starting at 8:15 AM 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 they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	{K 918}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	R **03/06/2024**

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 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 03/06/2024 for all previous deficiencies cited on 01/30/2024. 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, 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to conduct all required monthly activation of the fire alarm system. No documentation was available at the	{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 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. This checklist can be found in the State binder with other related information.	4/12/24

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

Electronically Signed | 03/22/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING _____	R 03/06/2024

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 345}	Continued From page 1 time of the survey to demonstrate that the monthly activation of the fire alarm system had been conducted since the initial survey on 01/30/2024. Also, no checklist had been created to document when the fire alarm system is activated each month, as was part of the approved plan of correction. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the administrator at the time of the exit acknowledge the deficiency.	{K 345}	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	
{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.	{K 353}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	R **03/06/2024**

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 2 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire sprinkler system in accordance with the 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 03/06/2024 starting at 8:15 AM revealed that the facility failed to perform the annual testing of the fire sprinkler system backflow preventer. No documentation was 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, and no documentation was available to demonstrate that the annual testing was scheduled to be completed. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated 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}	Plan of Correction: Green House Living will conduct all quarterly testing of the fire 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. Our vendor is scheduled to perform necessary backflow tests on 4 cottages on March 22, 2024. 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	
{K 761} SS=F	Maintenance, Inspection & Testing - Doors	{K 761}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	R **03/06/2024**

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 761}	Continued From page 3 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 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 had the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/06/2024 starting at 8:15 AM 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	{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 Safety Code training and verify the safety of all doors in accordance with NFPA 80. A checklist will be included in the binder of this inspection. 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	R **03/06/2024**

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 761}	Continued From page 4 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 they were aware 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}	order to maintain complete accuracy. Responsible Party: Facilities Director	
{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}		4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING 04 - FOUNDERS BUILDING B. WING _____	R 03/06/2024

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 918}	Continued From page 5 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 03/06/2024 starting at 8:45 AM 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 during 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **04 - FOUNDERS BUILDING** B. WING _____	R **03/06/2024**

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 918}	Continued From page 6 Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated they were aware 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 03/06/2024 starting at 8:15 AM 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 they were aware of the requirement. Interview with the administrator at the time of exit acknowledge the deficiency. Ref: 2010 NFPA 110 8.4.9	{K 918}		