STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**03/13/2025**

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 03/13/25. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in	E 018		4/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 018	Continued From page 1 the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and	E 018		

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E 018	Continued From page 2 secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide an acceptable procedure for tracking staff as required in accordance with §483.73(b)(2). Failure to provide an acceptable procedure for tracking of staff could result in inadequate tracking during an emergency event that requires relocation. The deficiency had the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/2025 starting at 2:00 PM revealed that the facility did not have documentation available to demonstration a procedure for tracking staff during an emergency. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	E 018	E018 Finding #1: Procedures for Tracking of Staff and Patients Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Director of Facilities Services and approved by the Emergency Preparedness Committee for GHL. What: The facility did not have documentation available to demonstration a procedure for tracking staff during an emergency. How: Director of Facilities Services will create a plan for tracking staff during an emergency and add it to the GHL Emergency Operation Plan. The altered plan will be presented to the Emergency Preparedness Committee for review and approval. When: Create procedure for tracking staff during an emergency. Incorporate the plan into the Emergency Operations Plan: 4/18/25 Monitor: Director of Facilities Support	

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E 018	Continued From page 3	E 018	will monitor the GHL Emergency Operation Plan to verify it has a procedure for tracking staff during an emergency.	
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	E 024		4/18/25

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E 024	Continued From page 4 *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide a policy or procedure for use of volunteers as required in accordance with §483.73(b)(6). Failure to provide a policy or procedure for use of volunteers could result in inadequate preparedness in the event of emergency staffing needs. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/2025 starting at 2:00 PM revealed the facility did not have documentation available to demonstration they had a policy or procedure for addressing the use of volunteers in an emergency. A policy or procedure shall be provided for the process and role of integration of State and Federally designated health care professionals to address surge needs during an emergency. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	E 024	E024 Finding #1: Procedures for Tracking of Staff and Patients Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Director of Facilities Services and approved by the Emergency Preparedness Committee for GHL. What: The facility failed to provide a policy or procedure for use of volunteers as required in accordance with 483.73(b)(6). How: Director of Facilities Services will create a procedure addressing the use of volunteers in an emergency. A policy or procedure shall be provided for the process and role of integration of State and Federally designated health care professionals to address surge needs during an emergency. This procedure will be added to the GHL Emergency Operation Plan. The altered plan will be presented to the Emergency Preparedness Committee for review and approval.	

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E 024	Continued From page 5	E 024	When: Create procedure for the use of volunteers during an emergency. Incorporate the plan into the Emergency Operations Plan: 4/18/25 Monitor: Director of Facilities Support will monitor the GHL Emergency Operation Plan to verify it has a procedure for the use of volunteers during an emergency.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/13/2025. 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 7 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. (Scott Building)	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/13/25. Requirements for Long Term Care Facilities	K 000		

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K 000	Continued From page 6 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 8 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. (Watt Building)	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/13/25. 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 4 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. (Whitney Building)	K 000		
K 000	INITIAL COMMENTS	K 000		

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K 000	Continued From page 7 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/13/25. 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 9 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90. (Founders Building)	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress could result in a delayed or inability to egress, resulting in injury or death in the event of	K 211	K211 Finding #1: Means of Egress - General Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services	4/18/25

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K 211	Continued From page 8 an emergency requiring evacuation. The deficiency affected multiple exterior exits used by staff, patients, and visitors. The findings were: Observation on 03/13/25 at 12:15 PM revealed three (3) north facing exterior exits with snow impeding egress to a public way. Observation of the north end patio area and walkways revealed a build up of several inches of snow. Three exit doors from the facility discharge to the north end patio and walkways which are part of the exit discharge to a public way. The snow would not have allowed for the safe evacuation of the facility if needed. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.2.1, 7.1.10.1	K 211	will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: Three (3) north facing exterior exits with snow impeding egress to a public way. Observation of the north end patio area and walkways revealed a build up of several inches of snow. Three exit doors from the facility discharge to the north end patio and walkways which are part of the exit discharge to a public way. The snow would not have allowed for the safe evacuation of the facility if needed. How: Director of Facilities Services will alter the Standard Work for snow removal to address the requirement to create an unimpeded path to the Public Way at all exits. When: Alter the Standard Work for snow removal to include the clearing of a path to the public way at all building exits. Plan will be altered: 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with an unimpeded pathway for exits from all buildings to the Public Way.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to	K 211		4/18/25

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K 211	Continued From page 9 full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly maintain the means of egress could result in a delayed or inability to egress, resulting in injury or death in the event of an emergency requiring evacuation. The deficiency affected multiple exterior exits used by staff, patients, and visitors. The findings were: Observation on 03/13/25 at 12:44 PM revealed three (3) north facing exterior exits with snow impeding egress to a public way. Observation of the north end patio area and walkways revealed a build up of several inches of snow. Three exit doors from the facility discharge to the north end patio and walkways which are part of the exit discharge to a public way. The snow would not have allowed for the safe evacuation of the facility if needed. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.2.1, 7.1.10.1	K 211	K211 Finding #1: Means of Egress - General Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: Three (3) north facing exterior exits with snow impeding egress to a public way. Observation of the north end patio area and walkways revealed a build up of several inches of snow. Three exit doors from the facility discharge to the north end patio and walkways which are part of the exit discharge to a public way. The snow would not have allowed for the safe evacuation of the facility if needed. How: Director of Facilities Services will alter the Standard Work for snow removal to address the requirement to create an unimpeded path to the Public Way at all exits. When: Alter the Standard Work for snow removal to include the clearing of a path to the public way at all building exits. Plan will be altered: 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with an	

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K 211	Continued From page 10	K 211	unimpeded pathway for exits from all buildings to the Public Way.	
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 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm 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 alarm system, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated	K 345	K345 Finding #1: Fire Alarm System □ Testing and Maintenance Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system	4/18/25

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

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K 345	Continued From page 11 the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. How: Director of Facilities Services will alter the Standard Work for fire alarm testing and documentation, and fire system battery testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire system testing and fire alarm battery testing altered to ensure tests completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required fire system including batteries testing.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the fire	K 345	K345 Finding #1: Fire Alarm System □ Testing and Maintenance	4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**03/13/2025**

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 12 alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm 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 alarm system, and could potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. How: Director of Facilities Services will alter the Standard Work for fire alarm testing and documentation, and fire system battery testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire system testing and fire alarm battery testing altered to ensure tests completion and documentation is place according to appropriate codes and standards. 4/18/25	

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K 345	Continued From page 13	K 345	Monitor: Director of Facilities Support will monitor the compliance with required fire system including batteries testing.	
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 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm 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 alarm system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to	K 345	K345 Finding #1: Fire Alarm System □ Testing and Maintenance Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to	4/18/25

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K 345	Continued From page 14 demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. How: Director of Facilities Services will alter the Standard Work for fire alarm testing and documentation, and fire system battery testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire system testing and fire alarm battery testing altered to ensure tests completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required fire system including batteries testing.	
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,	K 345	K345 Finding #1: Fire Alarm System □	4/18/25

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K 345	Continued From page 15 the facility failed to test and maintain the fire alarm system in accordance with the 2010 NFPA 72, National Fire Alarm and Signaling Code. Failure to properly test and maintain the fire alarm 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 alarm system and could potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 72 Table 14.4.5(24), Table 14.3.1(3)(d), Table 14.4.5(6)(3)	K 345	Testing and Maintenance Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all required monthly and semi-annual testing of the fire alarm system. Documentation was available to demonstrate that the required monthly activation of the fire alarm system was conducted two (2) of the last twelve (12) months. No additional documentation was available to demonstrate the fire alarm system been activated the other ten (10) months. Documentation was available to demonstrate that the fire alarm system batteries were inspected and tested in December of 2024. No additional documentation was available to demonstrate the fire alarm system batteries had been tested six (6) months prior. How: Director of Facilities Services will alter the Standard Work for fire alarm testing and documentation, and fire system battery testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire system testing and fire alarm battery testing altered to ensure tests completion and documentation is place according to appropriate codes and standards. 4/18/25	

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K 345	Continued From page 16	K 345	Monitor: Director of Facilities Support will monitor the compliance with required fire system including batteries testing.	
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 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	K 353	K353 Finding #1: Fire Sprinkler System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff.	4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 17 potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 at 2:45 PM revealed that the facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2011 NFPA 25 Table 5.1.1.2, Table 13.1.1.2	K 353	What: The facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. How: Director of Facilities Services will alter the Standard Work for fire sprinkler testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire sprinkler testing completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required fire sprinkler system testing, including quarterly testing requirements.	
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	K 353		4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 18 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 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 03/13/25 at 2:45 PM revealed that the facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12)	K 353	K353 Finding #1: Fire Sprinkler System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted	

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K 353	Continued From page 19 months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2011 NFPA 25 Table 5.1.1.2, Table 13.1.1.2	K 353	the other quarter of the previous twelve (12) months. How: Director of Facilities Services will alter the Standard Work for fire sprinkler testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire sprinkler testing completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required fire sprinkler system testing, including quarterly testing requirements.	
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		4/18/25

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K 353	Continued From page 20 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 03/13/25 at 2:45 PM revealed that the facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	K 353	K353 Finding #1: Fire Sprinkler System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. How: Director of Facilities Services will alter the Standard Work for fire sprinkler testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire sprinkler testing completion and documentation is place according to appropriate codes and standards. 4/18/25	

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K 353	Continued From page 21 Ref: 2011 NFPA 25 Table 5.1.1.2, Table 13.1.1.2	K 353	Monitor: Director of Facilities Support will monitor the compliance with required fire sprinkler system testing, including quarterly testing requirements.	
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 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	K 353	K353 Finding #1: Fire Sprinkler System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff.	4/18/25

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

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K 353	Continued From page 22 potentially affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 at 2:45 PM revealed that the facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2011 NFPA 25 Table 5.1.1.2, Table 13.1.1.2	K 353	What: The facility failed to conduct all required quarterly inspections and tests of the fire sprinkler system. Documentation was available to demonstrate that the facility had conducted quarterly inspections and tests of the water flow alarm, supervisory signal, dry system priming water, and dry system low air alarm for three (3) of the four (4) quarters of the last twelve (12) months. No additional documentation was available to demonstrate inspections and testing of the fire sprinkler system was conducted the other quarter of the previous twelve (12) months. How: Director of Facilities Services will alter the Standard Work for fire sprinkler testing and documentation to ensure compliance with appropriate standards. When: Standard Work for fire sprinkler testing completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required fire sprinkler system testing, including quarterly testing requirements.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**03/13/2025**

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

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K 712	Continued From page 23 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in an improper response by staff to an emergency, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from September of 2024 through February of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit	K 712	K712 Finding #1: Fire Drills Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from September of 2024 through February of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. How: Director of Facilities Services will alter the Standard Work for fire drills and documentation to ensure compliance with appropriate standards. When: Standard Work for fire drill completion and documentation is place	

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K 712	Continued From page 24 confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	according to appropriate codes and standards. 4/18/25 Monitor: Monitor: Director of Facilities Support will monitor the compliance with required fire drills. This includes required quarterly fire drills on each shift.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in an improper response by staff to an emergency, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed the facility failed to conduct all required	K 712	K712 Finding #1: Fire Drills Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had	4/18/25

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K 712	Continued From page 25 fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from October of 2024 through January of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	conducted quarterly fire drills on all shifts from September of 2024 through February of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. How: Director of Facilities Services will alter the Standard Work for fire drills and documentation to ensure compliance with appropriate standards. When: Standard Work for fire drill completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Monitor: Director of Facilities Support will monitor the compliance with required fire drills. This includes required quarterly fire drills on each shift.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		4/18/25

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K 712	Continued From page 26 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in an improper response by staff to an emergency, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from September of 2024 through December of 2024. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	K712 Finding #1: Fire Drills Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from September of 2024 through February of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. How: Director of Facilities Services will alter the Standard Work for fire drills and documentation to ensure compliance with appropriate standards. When: Standard Work for fire drill completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Monitor: Director of Facilities Support will monitor the	

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K 712	Continued From page 27	K 712	compliance with required fire drills. This includes required quarterly fire drills on each shift.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly conduct fire drills could result in an improper response by staff to an emergency, resulting in injury or death. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/13/25 starting at 2:45 PM revealed that the facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from November of 2024 through February of 2025. No additional documentation was	K 712	K712 Finding #1: Fire Drills Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to conduct all required fire drills. Documentation was available at the time of the survey to demonstrate that the facility had conducted quarterly fire drills on all shifts from September of 2024 through February of 2025. No additional documentation was available to demonstrate that fire drills had been conducted the previous quarters	4/18/25

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K 712	Continued From page 28 available to demonstrate that fire drills had been conducted the previous quarters of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.7.1.6	K 712	of the year. Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required. How: Director of Facilities Services will alter the Standard Work for fire drills and documentation to ensure compliance with appropriate standards. When: Standard Work for fire drill completion and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Monitor: Director of Facilities Support will monitor the compliance with required fire drills. This includes required quarterly fire drills on each shift.	
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	K 918		4/18/25

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K 918	Continued From page 29 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, 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: 1. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation	K 918	K918 Finding #1: Electrical Systems Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the	

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K 918	Continued From page 30 was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 110 8.4, 8.3.7.1 2. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	K 918	emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. How: Director of Facilities Services will alter the Standard Work for weekly and monthly tests of the emergency generator to ensure compliance with appropriate standards. When: Standard Work for emergency generator tests and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements. K918 Finding #2: Electrical Systems Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform the inspection and testing of main and feeder	

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K 918	Continued From page 31 Ref: 2012 NFPA 99 6.4.4.1.2.1	K 918	circuit breakers. No documentation was available at the time of the survey to show facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. How: Director of Facilities Services will create the Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. When: Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements.	
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.	K 918		4/18/25

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K 918	Continued From page 32 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, 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.	K 918	K918 Finding #1: Electrical Systems □ Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff.	

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K 918	Continued From page 33 The findings were: 1. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 110 8.4, 8.3.7.1 2. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. Interview with the director of facilities services at	K 918	What: The facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. How: Director of Facilities Services will alter the Standard Work for weekly and monthly tests of the emergency generator to ensure compliance with appropriate standards. When: Standard Work for emergency generator tests and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements. K918 Finding #2: Electrical Systems □ Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent	

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	535054	A. BUILDING **01, 02, 03, 04** B. WING _____	**03/13/2025**

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

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K 918	Continued From page 34 the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.4.1.2.1	K 918	further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to show facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. How: Director of Facilities Services will create the Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. When: Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements.	
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	K 918		4/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 35 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, 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	K 918	K918 Finding #1: Electrical Systems □ Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is	

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K 918	Continued From page 36 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: 1. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 110 8.4, 8.3.7.1 2. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for	K 918	addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. How: Director of Facilities Services will alter the Standard Work for weekly and monthly tests of the emergency generator to ensure compliance with appropriate standards. When: Standard Work for emergency generator tests and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements. K918 Finding #2: Electrical Systems □ Essential Electric System Maintenance and Testing	

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K 918	Continued From page 37 periodically exercising the components in accordance with manufacturer's recommendation. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.4.1.2.1	K 918	Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to show facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. How: Director of Facilities Services will create the Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. When: Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer□s recommendations. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		4/18/25

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K 918	Continued From page 38 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview,	K 918	K918 Finding #1: Electrical Systems □	

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K 918	Continued From page 39 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: 1. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2010 NFPA 110 8.4, 8.3.7.1 2. Document review on 03/13/2025 starting at 2:45 PM revealed the facility failed to perform the inspection and testing of main and feeder circuit	K 918	Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform all weekly and monthly inspections and tests of the emergency electrical generator. Documentation was available at the time of the survey to demonstrate that the facility had conducted the weekly and monthly inspections and tests of the emergency electrical generator from December of 2024 through March of 2025. No additional documentation was available to demonstrate inspections and testings had been conducted the previous months. How: Director of Facilities Services will alter the Standard Work for weekly and monthly tests of the emergency generator to ensure compliance with appropriate standards. When: Standard Work for emergency generator tests and documentation is place according to appropriate codes and standards. 4/18/25 Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing	

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K 918	Continued From page 40 breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 99 6.4.4.1.2.1	K 918	requirements. K918 Finding #2: Electrical Systems Essential Electric System Maintenance and Testing Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities Services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to show facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. How: Director of Facilities Services will create the Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer s recommendations. When: Standard Work for testing of main and feeder circuit breakers associated with the EES according to manufacturer s recommendations. 4/18/25	

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K 918	Continued From page 41	K 918	Monitor: Director of Facilities Support will monitor the compliance with required essential electrical system testing. This includes all weekly and monthly testing requirements.	
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 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	K 923		4/18/25

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K 923	Continued From page 42 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 properly store oxygen cylinders in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly store oxygen cylinders could result in damage to the cylinders and a release of oxygen gas, which could propagate the spread of smoke and fire resulting in injury or death in the event of a fire. The deficiency affected one (1) oxygen storage room, and has the potential to affect all residents, staff, and visitors. The findings were: Observation on 03/16/25 at 1:02 PM revealed an oxygen storage closet with several (E) size oxygen cylinders that were improperly stored. Additional observation revealed that two (2) of the cylinders were freestanding on the floor, and were not secured. Oxygen cylinders must be protected from damage by being properly chained or supported in a stand or cart. Interview with the director of facilities services at the time of the observation acknowledge the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit confirmed the deficiency.	K 923	K923 Finding #1: NFPA 101 Gas Equipment - Cylinder and Container Storage Who: SMH Director of Facilities Services will ensure the deficiency is addressed. Director of Facilities services will monitor the condition to prevent further non-compliance. The work will be completed by Facilities Services Staff. What: The facility failed to properly store oxygen cylinders. Oxygen storage closet revealed improperly stored (E) size oxygen cylinders. Two of the cylinders were freestanding on the floor without being properly chained or supported in a stand or cart. How: Director of Facilities Services will write Standard Work for weekly checkts to ensure the proper storage of oxygen. When: Standard work and appropriate storage will be in place by 4/18/25. Monitor: Director of Facilities Support will monitor the compliance with required oxygen storage standards.	

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K 923	Continued From page 43 Ref: 2012 NFPA 101 19.2.1, 7.1.10.1	K 923		