PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 000	INITIAL COMMENTS	F 000		
	The following common abbreviations are used throughout this document: CAA Care Area Assessment DON Director of Nursing MDS Minimum Data Set QAPI Quality Assurance and Performance Improvement RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency where used.			
F 170 SS=D	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, the facility failed to ensure mail was delivered unopened to 1 of 10 sample residents (#15). The findings were: In an interview on 6/25/13 at 7:15 PM, resident #15 stated the facility delivered opened mail to him/her in June 2013. The resident said it was upsetting because the letter "obviously" had been opened, and tape applied to reseal it. On 8/27/13 at 11:40 AM, during an interview, the administrator revealed the human resource manager accidently opened resident #15's mail. The human resource manager was interviewed later that day at 2:20 PM. At that time he stated he was responsible for sorting the mail. He further stated he frequently delivered the mail to	F 170	F170 Resident #15 will receive mail in a timely manner that is unopened. All elders will receive unopened mail in a timely manner. Daily mail shall be sorted into two separate groups, with the unopened elder mail delivered to the social worker or available administration personnel, who will distribute the mail to the specifically addressed elders within that same day, Mon. - Fri. Saturday delivery mail shall be sorted (and remain unopened) by the nurse on duty for the	8/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski | TITLE: Administrator | (X6) DATE: 8/19/13

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.

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 170	Continued From page 1 the cottages; but he did not remember opening resident #15's mail. In an interview on 6/27/13 at 2:35 PM, the administrator revealed the facility had not completed a root cause analysis to identify measures that could be implemented to prevent recurrrent right to privacy issues related to mail delivery.	F 170	Scott Cottage where the mailbox key resides. He/she will return the Green House Living for Sheridan mail back into the mailbox (for opening on Monday). The Scott nurse will pass off the Watt and Founders' elder mail to the other nurse on duty so that he/she can distribute the mail to the specifically addressed elders within that same day. No mail will be opened. At each quarterly review, the social worker will ask the elder and/or family member if they have been receiving their mail unopened and in a timely manner. If they are not, the social worker will investigate the reasons why and report back to the elder and/or family what was done to resolve the problem. At each QA meeting the social worker will report the number of elders who are not satisfied with mail condition and/or delivery and what has been done to correct this. Negative trends will be addressed and a plan of action will be initiated to resolve the problem.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274		8/23/13

8/21/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 274	Continued From page 2	F 274		

means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to perform required significant change MDS assessments for 2 of 10 sample residents (#18, #26). The findings were:

1. Resident #18 was admitted to the facility on 9/17/12. Review of the resident's admission MDS assessment, dated 9/21/12, revealed his/her weight at the time of admission was 134 pounds. Review of weight records kept by the facility revealed the following resident weights, by date:
a. 12/7/13, 132.8 pounds.
b. 1/5/13, 127.8 pounds.
c. 2/2/13, 122.0 pounds.
d. 3/2/2013, 111.6 pounds (a 15.96% loss over 3 months.)
e. 4/6/13, 109.0 pounds.
f. 5/4/13, 106.4 pounds.
g. 6/15/13, 95.0 pounds (a 28.46 % loss over 6 months.)

Further review of the resident's medical record revealed that, although quarterly MDS assessments were completed in a timely manner, no comprehensive MDS assessment had been completed for the resident since the admission MDS assessment dated 9/21/12.

F 274 Green House Living for Sheridan will ensure that all Elders living in our cottages will have a comprehensive assessment completed within 14 days after we determine that there has been a significant change in the resident's physical or mental condition. This will be accomplished by:

1. MDS Coordinator hours will be increased effective Aug., 2013, for assessment and care planning purposes. The MDS Coordinator will complete MDS coursework program by September 15, 2013 that addresses the comprehensive assessment process.

2. Significant Change MDS has been completed for Elder #18 and for Elder #26 and Care Plans have also been updated.

3. Dietary Manager will review weights on all Elders on a weekly basis through ECS. Dietary Manager will notify both Registered Dietitian and MDS Coordinator of any weight loss of >5% in 30 days or 10% in 180 days.

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 274	Continued From page 3 2. Review of the medical record showed resident #26 was admitted to the facility on 2/1/12. Review of weight records maintained by the facility revealed the following resident weights, by date: a. 12/8/12, 114 pounds. b. 1/5/13, 114 pounds. c. 2/23/13, 113.4 pounds. d. 3/16/13, 110 pounds. e. 4/13/13, 106.4 pounds. f. 5/11/13, 95 pounds. g. 6/8/13, 100.2 pounds (a 12.1% loss over 6 months.) Further review of the resident's medical record revealed quarterly MDS assessments were completed in a timely manner; but a comprehensive MDS assessment had not been completed for the resident since the annual MDS assessment dated 1/23/13. Interview on 6/27/13 at 2:25 PM with the RN who was responsible for completeing MDS assessments revealed she was unaware of the requirement to complete a significant change assessment for unintended weight loss of greater than 5% in 30 days or 10% in 180 days. She further stated measures to address the weight loss had been implemented, but she did not if these measures would have been implemented sooner if the significant change assessments had been completed according to the regulations.	F 274	4. Registered Dietitian, Dietary Manager, MDS Coordinator, and Director of Nursing will meet on a monthly basis to review and discuss all weight changes occurring at GHLS and Care Plan any necessary changes. 5. MDS Coordinator will conduct chart audits on a weekly basis through ECS to monitor changing conditions and report to DON any significant changes. Any discrepancies will be resolved. 6. The DON will report on the number of significant change assessments to the QA committee and negative trends will be discussed and a plan of action initiated if needed.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		8/23/13

8/26/13

PRINTED: 08/16/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 278	Continued From page 4 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to accurately identify wounds on assessment for 2 of 2 sample residents (#9, #40) identified with wounds. The findings were: 1. Review of the 4/19/13 admission MDS assessment for resident #9 showed s/he was assessed as having 5 pressure ulcers. Review of the corresponding CAA showed the resident had venous stasis ulcers without pressure ulcers.	F 278	F- 278 Green House Living for Sheridan will ensure that all Elders living in our cottages will be accurately assessed, based on their status, and the MDS will accurately reflect that status. This will be accomplished by: 1. The MDS for Elder #9 has been re-coded and submitted to reflect venous stasis ulcers.	

8/28/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 278	Continued From page 5 During an interview on 6/26/13 at 3:45 PM, the resident stated s/he had skin issues as a result of his/her vascular issues, but no pressure ulcers. At that time s/he refused to allow the surveyor to observe the areas. 2. Review of the 9/26/12 admission MDS assessment for resident #40 showed s/he was assessed as having 1 stage II pressure ulcer. However, observation on 6/25/13 at 10:17 AM showed the resident had 1 fistula on the peri-rectal area, but no pressure ulcers. During an interview with RN #2 on 6/25/13 at 10:30 AM, she confirmed the resident did not have pressure ulcers. She also stated the resident had the fistula prior to admission as a result of cancer. 3. During an interview with RN #3 on 6/27/13 at 2:25 PM, she revealed she was responsible for completing the MDS assessments. She stated she incorrectly coded non-pressure ulcers as pressure ulcers for residents #9 and #40 because she did not know how to code non-pressure ulcers on the MDS. She further stated she had not received formal MDS training and was only scheduled to work about 20 hours a week on MDS assessments and care plans.	F 278	2. The MDS for Elder #40 has been re-coded and submitted to reflect a fistula. 3. MDS Coordinator hours will be increased effective Aug., 2013. The MDS Coordinator will complete MDS coursework program to be completed by September 15, 2013. 4. The MDS Coordinator and DON will meet on a weekly basis to discuss questions related to MDS coding. 5. Weekly meeting results on skin condition will be reported to the QA meeting and negative trends will be discussed. A plan of action will be initiated if needed.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		8/1/13

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 279	Continued From page 6 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and resident and staff interview, the facility failed to utilized the care planning process to address all of the identified problems for 4 of 10 sample residents (#3, #15, #18, #26). The findings were: 1. Review of the 6/5/13 annual MDS assessment for resident #3 showed areas triggered for comprehensive assessment and care planning included the following: visual function, communication, psychosocial well-being, activities, dehydration-fluid maintenance, and pressure ulcers. Review of the resident's care plan showed these areas were not addressed. 2. Review of the medical record for resident #26 showed the resident was admitted to the facility on 2/1/12 with diagnoses that included non-Alzheimer's dementia, depression, constipation, edema and a history of falls. Review of the 1/23/13 annual MDS assessment revealed care area assessments (CAA) were triggered for 13 areas including pain and dehydration/fluid	F 279	F279 Green House Living for Sheridan will ensure that all Elders living in our cottages will have a comprehensive care plan to address all of the identified problems based on a thorough assessment. This will be accomplished by: 1. Upon completion of Nursing Admission Assessment, an admission temporary care plan will be initiated in ECS. This care plan is based on the charting done at admission. These will be completed within the first three days from admission. 2. Upon completion of MDS, an MDS temporary care plan will be initiated through ECS. This care plan is based on the MDS and ensures that the responses chosen on the MDS are reflected in the Care Plan. These care plans serve as a basis for the final development of each problem, and will be individualized. Care Plans will be finalized after initial Care Conference with Elder,	

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 279	Continued From page 7	F 279		

maintenance. Although the CAAs indicated a decision to care plan for the areas of pain and dehydration/fluid maintenance, a review of the resident's 6/24/13 care plan showed these triggered areas were not included.

3. Review of the medical record for resident #18 showed the resident was admitted to the facility on 9/17/12 with diagnoses that included dental plaque and cachexia. Review of the admission MDS assessment dated 9/21/12 revealed CAAs were triggered for 10 areas including dental care. Review of the CAAs showed staff determined care plan interventions were needed for dental care. However, review of the 6/24/13 care plan showed dental care had not been addressed. Review of the resident's medical record showed s/he underwent surgical removal of 18 teeth on 6/21/13.

4. Review of the medical record for resident #15 revealed the resident was admitted to the facility on 9/25/12 with an insulin pump. Further review showed the resident required intermittent urinary catheterization to empty his/her bladder. During an interview on 6/27/13 at 7:15 PM, the resident stated s/he did the intermittent urinary catheterization and managed the insulin pump without staff assistance. At that time the resident showed the attached insulin pump to the surveyor. Review of the care plan, showed information regarding the intermittent urinary catheterization and insulin pump was lacking.
5. During an interview with RN #3 on 6/27/13 at 2:25 PM she confirmed the care plans for residents #3, #15, #18, and #26 needed to be revised. She further stated the care plan revisions had not been done because working as a staff nurse only allowed her about 20 hours a week to

family members, and interdisciplinary team. Chart audits will be done weekly by the DON.

3. Care Plans will be reviewed on a monthly basis by nurses who work in the cottages. They will be added to other monthly charting, such as Falls Risk, Braden, and AIMS. The QA Coordinator will randomly monitor the care plans and findings will be reported quarterly at the QA meeting.

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 279	Continued From page 8	F 279		
	devote to MDS assessments and care plans.			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of Material Safety Data Sheet (MSDS) documentation, the facility failed to ensure unsafe chemicals were secured in 4 of 4 resident cottages (Founder, Scott, Whitney, Watt). The findings were: A partially used bottle of Cen-Kleen IV (a cleaning solution) was observed in an unlocked cabinet in the sauna room in each of the four cottages. This cleaning solution was observed in Founder Cottage on 6/25/13 at 3:32 PM, in Scott Cottage on 6/25/13 at 3:55 PM, in Whitney Cottage on 6/26/13 at 3:25 PM, and in Watt Cottage on 6/27/13 at 11:55 AM. During an interview on 6/27/13 at 4:10 PM, RN #2 confirmed the sauna rooms and cabinets in each cottage were not routinely locked. In an interview on 7/5/13 at 9:45 AM, the DON stated residents (#2, #4, #7, #22, #29, #30, #32, #34, #35, #36, #38, #39, #43) who reside in the cottages and had dementia had poor safety awareness and potentially would not recognize hazardous chemicals. The following	F 323	F323 Cen Kleen IV bottle has been removed from the spa disinfecting closet so that residents with dementia will not have access to this chemical. All Shabazim will be educated on this at the team meetings, and that they can only have shampoo and bathing products on the floor of the closet. To assure that the spa disinfecting closets contain no cleaning chemicals, Maintenance will check weekly at the same time the disinfecting chemical is added to the locked dispensing unit on the wall. Maintenance will also lock up the cleaning solution in their storage area so it cannot be accessed by any other staff members. Also, the Guide will include this observation on her checklist to assure that the spa disinfecting closet does not contain any cleaning compounds.	7/26/13

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 323	Continued From page 9 residents were identified as having dementia: a. Watt Cottage: non-sample residents #2, #4, #32. b. Founders Cottage: non-sample residents #7, #36, #43 c. Whitney Cottage: non-sample resident ##22 and sample resident #29. d. Scott Cottage: non-sample residents #30, #34, #35, #38, #39. According to the MSDS form for Cen-Kleen IV, overexposure caused burns. The following instructions are given, "EMERGENCY FIRST AID PROCEDURES: SKIN: Wash with soap and water; flush with flowing water for 15 minutes. See physician if burning persists. EYES: Flush with flowing water for 15 minutes and see physician. INHALATION: Remove to fresh air. INGESTION: Give a teaspoon of milk of magnesia, followed with milk or water to dilute material, and/or raw egg whites. Avoid alcohol. CALL A PHYSICIAN OR POISON CONTROL CENTER IMMEDIATELY. NEVER GIVE ANYTHING BY MOUTH TO AN UNCONSCIOUS PERSON."	F 323	Results of the Maintenance and Guide walk-throughs will be reported at the QA meeting, and any exceptions will be noted, along with the solutions applied. Negative trends will be addressed and a plan of action will be initiated to resolve the problem.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		8/1/13

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 441	Continued From page 10 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of infection control records, and medical record review, the facility failed to develop and implement an effective infection control program. The findings were: 1. Regarding surveillance activities: a. Review of the medical record for resident #18 showed a urine culture and sensitivity was submitted to the laboratory on	F 441	F441 Green House Living for Sheridan will ensure that its infection control program provides for a safe, sanitary, comfortable environment; and that it helps to prevent the development and transmission of disease and infection. This will be accomplished by: 1. Lab Log Book will be placed in each of the four cottages. This will assure that all lab orders are entered into the book, that the	

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 441	Continued From page 11	F 441		

12/18/12 and antibiotic therapy was initiated. Review of the urine culture and sensitivity report showed the test was completed on 12/20/12; however, this information was not faxed to the physician until 12/24/12. Review of this laboratory report also showed the antibiotic that was being administered to the resident at that time was ineffective. According to the physician's orders, the ineffective antibiotic was not changed to an antibiotic identified by the laboratory results as effective until 12/27/12 (a delay of seven days until the appropriate antibiotic was administered.) Interview with the DON on 6/26/13 at 2 PM confirmed the delay in treating the urinary tract infection with the appropriate antibiotic. Review of the surveillance records, including the infection control logs, from December 2012 to June 2013 showed a system for monitoring for appropriate antibiotic use had not been incorporated into the surveillance process.

b. Observation on 6/27/13 at 9:20 AM showed RN #1 used a glucometer to perform a glucose test for resident #15. The RN did the test with ungloved hands, then touched dining table and kitchen counter surfaces and the computer lap top before she performed hand hygiene. Observation on 6/27/13 at 9:50 AM showed the same RN administered insulin to resident #22 with ungloved hands. Further observation revealed after the insulin was administered, the RN used her ungloved hands to place a Band-Aid over the bleeding injection site. Interview with the RN at that time revealed she had not used acceptable infection prevention practices for the glucose testing and insulin administration because she was nervous and her forget to wear gloves. Review of the surveillance records showed no system for reviewing practices directly related to resident care in order to identify

specimens have been collected, the physician has been notified, and appropriate treatment has been initiated.

2. A staff R.N. has been designated as the Infection Control Coordinator for GHLS.

3. IC Coordinator will monitor all new infections in the facility and monitor the sensitivities of organisms through Sheridan Memorial Hospital's Cerner system to be certain of proper antibiotic use. Physicians will be notified directly by the hospital & by GHLS nurses of lab results.

4. During Infection Control meetings, committee members will review all antibiotics prescribed for the month and monitor for appropriateness. Negative trends will be discussed, and a plan of action initiated.

5. All infections are documented in ECS by the DON in the QA Chart on Infection folder and are charted on until the infection is resolved.

6. R.N. #1 has been counseled on universal precautions, and is aware of infection prevention practices.

7. QA Coordinator and IC Coordinator will perform random observations on staff hygiene practices and report results to Infection Control Committee and quarterly to QA meeting. Action plans will be developed for negative trends.

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 441	Continued From page 12 whether the practices comply with established prevention and control procedures. 2. Review of the Infection control activities and interview on 6/27/13 at 11:10 AM with the DON and administrator revealed the following additional elements were lacking in the program: a. A system for conducting data analysis that helps to detect unusual or unexpected outcomes and to determine the effectivess of infection prevention and control practices. b. The infection control program had not been incorporated into the facility-wide QAPI program.	F 441		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a significant laboratory result in a timely manner, with the result the resident went an additional 7 days without appropriate treatment. This occurred in 1 of 10 sample (#18) residents. The findings were: Review of the medical record for resident #18 showed a urine culture and sensitivity was submitted to the laboratory on 12/18/12. Review of the culture and sensitivity results showed testing was completed on 12/20/12; however, test results were not faxed to the physician until 12/24/12. The order to change the resident's	F 505	F505 Green House Living for Sheridan will ensure that attending physicians are notified promptly of lab results. This will be accomplished by: 1. Lab Log Book will be placed in each of the four cottages. This will assure that all lab orders are entered into the book, that the specimens have been collected, the physician has been notified and appropriate treatment has been initiated. All nursing personnel will be trained regarding this policy by August 1, 2013. 2. Will inform Medical Director that we will again need to fax all lab results to physicians at next Executive Review meeting,	8/1/13

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 505	Continued From page 13 antibiotic medication from an ineffective antibiotic to one indicated by the laboratory results was not received until 12/27/12, all of which resulted in a seven day delay in starting appropriate treatment. Interview with the DON on 6/26/13 at 2 PM confirmed the delay in treating the resident's urinary tract infection with the appropriate antibiotic and further confirmed the facility expectation is that laboratory results are to be acted on quickly by nursing staff.	F 505	July 25, 2013. 3. DON will monitor lab logs to assure information is updated and communicated in a timely manner. 4. DON will report to QA how the lab log is working.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		8/30/13

8/26/13

PRINTED: 06/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F 520	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of QAPI activities the facility failed to ensure an effective QAPI program was implemented. The findings were: 1. Interview with the administrator and DON on 6/27/13 at 11:10 AM revealed their QAPI program consisted of routine reviews of the facility's Centers for Medicare & Medicaid Services (CMS) Quality Measure Reports (The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay. These measures assess residents' physical and clinical conditions and availability as well as preferences and life care wishes). During the interview they stated the reports were reviewed and discussed at the quarterly meetings, but no actions resulted from the discussions. Review of the documented QAPI activities confirmed the QAPI committee conducted quarterly meetings and the Quality Measure Reports were reviewed. The administrator and DON were unable to provide evidence of the following elements in their QAPI program: a. A process that addressed all systems of care and management practices, including clinical care, quality of life and resident choice. b. A system for identifying and monitoring a wide range of care processes and outcomes and established performance indicators, benchmarks, and goal. 2. Additional concerns regarding the QAPI program were identified during review of the	F 520	F520 GHLS will utilize a process of reviewing quality indicators for quality of care, and developing a process for reviewing quality of life, safety and management practices. Medication self-administration, infection prevention, care plan development, and safety practices will be included in these processes. At the QA meeting of 9/26/13, we will review quality indicators and choose 3 areas that we would like to address concerning quality of care, quality of life and safety. From Sept. 2013, to Dec. 2013, data collection will begin. By the December QA meeting, we will analyze the data that has been collected to determine the performance improvement project (PIP) and related goals.	

8/26/13

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 06/27/2013

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
F-520	Continued From page 15 effectiveness of the QAPI program during the past year. Review of the CMS-2567 for last year's initial survey, dated 5/27/12, revealed a deficiency was written for F176 related to self-medication administration, F279 related to developing care plans, F323 related to safety and hazards, and F441 related to infection prevention. These same issues were identified as concerns during the current survey conducted 6/24/13 to 6/27/13.	F-520		

8/26/13