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

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 The following common abbreviations are used throughout this document: CNA/Shahbaz — Certified Nurse Aide DON — Director of Nursing LPN — Licensed Practical Nurse MDS — Minimum Data Set PRN — Pro re nata, as needed RN — Registered Nurse Shahbazim — Plural of Shahbaz Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157	Green House Living for Sheridan (GHLS) will ensure that physicians will be notified of any change of condition in their residents. This will be accomplished by: 1. When an Elder makes statements regarding self-harm, suicide, or other mental health issues, the nurse will immediately assess his mental state and document any interventions, including appropriate referrals. If potential for self-harm is evident the nurse will immediately notify the DON. The DON will notify and seek further direction from the attending physician. 2. Social Worker (SW) will perform chart review of all elders who have triggered for mood or psychosocial problems on the MDS. If any elders have statements of self-harm in their chart within the past three months, SW will assess for current mental health status and that appropriate interventions on the Care Plan.	12/5/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski — TITLE: Administrator — (X6) DATE: 12/4/14

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.

12/17/14 - Plan of correction accepted with changes, confirmed with Administrator @ 4:20pm (Chris Szymanski). Date of compliance is 12/5/14 J. VanDyke, RN

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536064	A. BUILDING _____ B. WING _____	C 10/22/2014

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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. 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 change in condition for 1 of 1 sample residents (#26) who had a change in condition. The findings were: Review of the medical record showed resident #26 had diagnoses that included depression and anxiety. Review of physician orders showed the resident's Paxil (anti-depressant medication) was increased on 8/18/14 to 30 mg daily. Review of the 8/21/14 nursing "Emotional Monthly Summary" showed the resident's daughter had recently moved away which "created worries" for the resident. The resident recently changed anti-depressant medications and then also had an increase of the new medication Paxil. Review of nurses' notes for September 2014 showed the resident's mood and behaviors were monitored for anxiety and depression which included preoccupation with pain, itching, bad dreams, being too warm, and family concerns. Review of the nurse's note dated 9/8/14 timed at 6:26 PM showed, the resident "feels tired/little energy indicates (s)he feels bad about self, is failure, or has let self or family down '[s/he] would jump off a	F 157	F 157 - Continued from above: 3. When "BEHAVIOR" charting is documented in the EMR, an immediate alert will be sent to DON, Social Worker (SW), and MDS Coordinator. DON and MDS Coordinator will monitor behavior charting during their weekly meeting. The notification alert will be installed in the EMR by 11/14/2014. 4. After receiving the Alert Notification, SW may meet with Elder and chart a progress note regarding Elder's mental state. Elder's Care Plan will also be updated based on SW's findings. 5. Physician was notified of Elder #26's suicidal statements on 11/08/2014. 6. Policy regarding Suicide Threats was updated 11/11/2014 and all nurses were in-serviced at the 11/12/2014 Nurses' Meeting. 7. On a monthly basis, the SW will summarize the number of behavior incidences that required intervention to the Safety Committee. Any negative trends will be addressed and a plan of action initiated, if needed. 8. Change of Condition process as it relates to mental status will be monitored by the DON and MDS Coordinator and the results reported at the QAPI meeting.	

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 157	Continued From page 2 bridge [s/he] feels so bad'." The note did not show any action taken related to the resident's statements. An additional note made by the same nurse on 9/8/14 at 9:06 PM showed the resident "Came to the nurses office crying, reports that [s/he] feels so bad inside [s/he] would like to figure out a way to end it all, like if [s/he] jumped off of the bridge. Kept to [her/him] self tonight." The note showed no action was taken regarding these statements. The next nurse note was 9/9/14 at 5:39 AM with no problems noted. Interview with the DON on 10/22/14 at 11:33 AM verified she was unable to find any evidence the physician was notified concerning the resident's increased depression and suicidal statements.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	Green House Living for Sheridan will ensure Shahbazim are listed on the Wyoming CNA Abuse Registry. This will be accomplished by: 1. A comprehensive review of all current employees (including Shahbazim 1, 2 and 3) against the online registry was accomplished immediately upon notification from the Survey Team on 10/19/2014 with no additional unlisted employees found. Another full review was conducted on 11/03/2014. 2. An HLS/CNA Form 109 and current Wyoming CNA License were faxed to WYDOH License and Surveys office for immediate review and inclusion to the online CNA Abuse Registry for Shahbazim 1, 2 and 3. Printed copies of the CNA Form 109's and the proof of transmission fax sheets were placed in their personnel records. 3. The HR Manager will check all current Shahbazim for inclusion on the CNA Abuse	11/03/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 225	Continued From page 3 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on facility record review, review of the Wyoming CNA Abuse Registry, and staff interview, the facility failed to ensure 3 of 10 recently hired Shahbazim (#1, #2, #3) were listed on the Wyoming Abuse Registry. The findings were: Review of the facility listing of recent hires revealed 10 Shahbazim had been hired by the facility since 6/27/14. Review of the Wyoming CNA Abuse Registry on 10/21/14 showed 3 (#1, #2, #3) were not listed on the registry. These 3 Shahbazim all had a hire date of 9/2/14, and all 3 were on the work schedule. Interview with the facility administrator on 10/21/14 at 4:20 PM confirmed the person responsible for checking the CNA abuse registry had not ensured the recent hires were listed on the registry before they began work at the facility.	F 225	F 225 - Continued from above: Registry monthly. As part of ongoing quality assurance monitoring, the Guide/Educator will check to ensure that each new hired Shahbaz has been listed on the CNA Abuse Registry prior to any in-house training at time of hire. If the Shahbaz has not been properly cleared, the HR Manager will be immediately notified and the Shahbaz will not be allowed to work with Elders until Registry verification can be done. HR "Hiring Policy" was updated on 11/14/2014. 4. HR Manager will notify QA Manager monthly of any Shahbazim who are not currently on the registry with a plan of action. 5. HR Manager will report on abuse registry listings at the QAPI meeting and any negative trends will be addressed.	

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of policy and procedures and staff interview, the facility failed to ensure the required timeframe was included in the abuse/neglect prohibition policy and procedures related to reporting to the state survey agency. The findings were: 1. Review of the policy and procedure titled "Reporting Abuse to State Agencies and Other Entities/Individuals," last revised on 7/14/14, showed the administrator or designee would "promptly" report "suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse...Verbal/written notice to agencies will be made within forty-eight (48) hours of the occurrence..." 2. Review of the policy and procedure titled "Protection of Elders During Abuse Investigations," revised on 7/15/14, showed within 5 working days of the alleged incident the facility will provide a written report of the findings of the investigation and a summary of the corrective actions taken. This policy and procedure did not include any information related to the initial reporting requirement.	F 226	Green House Living for Sheridan will ensure the required timeframe is included in the abuse/ neglect prohibition policy and procedures related to reporting to the state survey agency. This will be accomplished by: 1. "Abuse Investigations" policy will be corrected to reflect current reporting guidelines. 2. Administrative staff will be in-serviced on the updated policy and current reporting guidelines by 11/30/2014. 3. Abuse policies will be reviewed annually and revised as needed. 4. The Social Worker will report any negative trends to the QAPI Committee.	11/30/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 226	Continued From page 5 3. Review of the policy and procedure titled "Abuse Investigations," revised on 7/15/14, failed to include any requirement for initial reporting to the state survey agency of any allegation of abuse, neglect or misappropriation of resident property. 4. Interview with the social worker on 10/21/14 at 4:05 PM revealed she was unaware the policy and procedures did not contain the correct timeframe for reporting.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to ensure psychosocial and mental health needs were met for 1 of 1 sample residents (#26) with these types of needs. The findings were: Review of the medical record showed resident #26 had diagnoses that included depression and anxiety. Review of physician orders showed the resident's Paxil (anti-depressant medication) was increased on 8/18/14 to 30 mg daily. Review of the 8/21/14 nursing "emotional monthly summary" showed the resident's daughter had recently moved away which created worries for the resident. The resident recently changed	F 250	Green House Living for Sheridan will ensure mental and psychosocial needs are met to attain or maintain the highest practicable well-being of each resident. This will be accomplished by: 1. When an Elder makes statements regarding self-harm, suicide, or other mental health issues, the nurse will immediately assess his mental state and document any interventions, including appropriate referrals. If potential for self-harm is evident, the nurse will immediately notify the DON. The DON will notify and seek further direction from the attending physician. 2. SW will perform chart review of all elders who have triggered for mood or psychosocial problems on their care plans. If any elders have statements of self-harm within the past three months (Sept. - Nov.), SW will assess for current mental health status and update the Care Plan with appropriate intervention(s).	12/5/2014

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 10/22/2014

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 250	Continued From page 6 anti-depressant medications and then also had an increase of the new medication Paxil. Review of nurses' notes for September 2014 showed the resident's mood and behaviors were monitored for anxiety and depression which included preoccupation with pain, itching, bad dreams, being too warm, and family concerns. The following concerns were identified: a. Review of the nurse's note dated 9/8/14, timed at 5:36 PM, showed the resident "feels tired/little energy indicates (s)he feels bad about self, is failure, or has let self or family down '[s/he] would jump off a bridge [s/he] feels so bad.'" The note did not show any action taken related to the resident's statements, it only showed the nurse had taken the resident's pulse and it was 78. b. The next note documented on 9/8/14 at 9:06 PM showed the resident "Came to the nurses office crying, reports that [s/he] feels so bad inside [s/he] would like to figure out a way to end it all, like if [s/he] jumped off of the bridge. Kept to [her/him] self tonight." The note showed no action was taken regarding these statements, and there were no other nursing notes until the next morning on 9/9/14 at 5:39 AM with "no problems noted." c. Review of the depression/anxiety care plan showed it was last updated on 1/22/14. The nurse's approach was dated 9/21/13 and showed they were to reinforce strengths, administer medications and evaluate the effectiveness and adverse effects. The approach dated 1/24/14 showed social services was to "provide emotional support meet with elder as needed to discuss concerns and mood." The following concerns were identified: d. Interview with the social worker on 10/21/14 at 4:05 PM revealed she was not aware of the resident's statements about suicide. She	F 250	F 250 - Continued from above: 3. When "BEHAVIOR" charting is documented in the EMR, an immediate alert will be sent to DON, Social Worker (SW), and MDS Coordinator. DON and MDS Coordinator will monitor behavior charting during their weekly meeting. The notification alert will be installed in the EMR by 11/14/2014. 4. After receiving the Alert Notification, SW may meet with Elder and chart a progress note regarding Elder's mental state. Elder's Care Plan will be updated based on SW's findings. 5. Physician has been notified of Elder #26's suicidal statements on 11/08/2014 and Elder #26's care plan has been updated on 11/12/2014 to address the Elder's needs about self and family, including expressing suicidal statements. 6. Policy regarding Suicide Threats was updated 11/11/2014 and all nurses were in-serviced on the revised policy on 11/12/2014. 7. Daily social service risk review tool in EMR will be reviewed by the SW. SW will follow up on identified issues and update the Care Plan as needed. 8. Green House Living for Sheridan has contracted with a psychological services firm to provide mental health services.	

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 250	Continued From page 7 further revealed her documentation usually consisted of quarterly notes related to the MDS assessments. The social worker stated she spoke with the resident daily when mail was delivered. However, the social worker stated there was no plan or goals in place to address the resident's needs about self, family or other concerns. e. Interview with the resident on 10/20/14 at 9:50 AM revealed s/he was unable to see well, had chronic pain in his/her back, had no family in the area, and was "lonely." The resident further stated the staff were too busy and did not have time to sit and talk with him/her. f. Interview with the DON on 10/22/14 at 11:33 AM verified she was unable to find any evidence the physician was notified concerning the resident's increased depression and suicidal statements from 9/8/14. In addition, the DON stated she and the social worker should have been notified of the resident's mood and they were not. The DON then confirmed the resident's psychiatrist who had been managing his/her medications had left in September 2014 and the resident was no longer being seen by a mental health practitioner.	F 250	F 250 - Continued from above: 9. SW will summarize the number of behavior incidences on a monthly basis that required intervention and report them to the Safety Comm. Mtg. SW will assess quarterly, and as needed, that mental and psychosocial needs are being met, initiate corrective action as needed, and report any negative trends to QAPI.	
F 279 SS=D	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 needs that are identified in the comprehensive	F 279	Green House Living for Sheridan will ensure that all Elders have a comprehensive care plan that includes measurable objectives and timetables, and is individualized for each Elder. This will be accomplished by: 1. Elder #13 has an acceptable level of pain of 4 on a scale of 0-10 on his Care Plan after speaking with the MDS Coordinator on 11/13/2014. His acceptable reasonable time of achieving that pain control is one hour.	12/5/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 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 staff interview, the facility failed to develop a comprehensive care plan for 2 of 12 sample residents (#13, #26). The findings were: 1. Review of the medical record showed resident #13 was admitted to the facility 6/18/12 with diagnoses including chronic pain syndrome. Review of the 9/7/14 annual MDS assessment showed the resident had frequent pain which made it difficult for him/her to sleep. The resident rated the pain level as 8 on a scale of 0 to 10 with 10 being the worst (8/10). Review of the 9/17/14 care plan showed the goal was "Expressed feelings of comfort or of pain relief within reasonable time after pain med administration, Says pain meds are effective." However, no acceptable level of pain was identified for this resident and "reasonable time" was not defined. In addition, the nursing approaches were not individualized for this resident. Approaches included "Assess physical symptoms. Anticipate pain and treat. Assess attitudes regarding pain. Ask about pain regularly. Use verbal pain	F 279	F 279 - Continued from above: 2. Care Plan for Elder #26 has been updated by MDS Coordinator to include the individualized triggers for Elder's anxiety and depression, and specific approaches. 3. MDS Coordinator will review all charts for care plans with pain, and/or depression as a concern, and corrected, if necessary, to ensure there is a measurable goal for pain management. 4. Before each quarterly care plan meeting, interdisciplinary team will review care plan for current problems, individualized approaches and interventions, and appropriate and measurable goals. Care Plan will be updated after the Care Plan meeting and as needed to reflect current level of care. QA Manager will attend all Care Plan meetings to monitor for negative trends. 5. Negative trends will be reported out to the QAPI committee on a quarterly basis and a plan of action initiated as needed. 6. GHLS Care Plan policy and procedure was reviewed and updated 11/13/2014. 7. DON ~ MDS coordinator will review selected care plans on a weekly basis to ensure they are complete and individualized. This effort is ongoing.	

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 9 assessment tool. Use non-verbal assessment tool. Administer pain meds and note effectiveness/adverse effects. Encourage exercise. Notify physician of changes. Educate regarding pain medications." Review of the care plan showed no evidence parameters or measurements were identified to determine the effectiveness of pain management or to "assure adequate pain control." Interview with the DON on 10/22/14 at 11:55 AM verified the care plan should have been more specific to the resident. 2. Review of the medical record showed resident #26 had diagnoses that included depression and anxiety. Review of the 8/21/14 nursing "emotional monthly summary" showed the resident's daughter had recently moved away which "created worries for the resident." The note also showed the resident had recently changed anti-depressant medications and also had an increase of the new anti-depressant medication Paxil. Review of nurses' notes for September 2014 showed the resident's mood and behaviors were monitored for anxiety and depression, and the resident had episodes of being preoccupied with pain, itching, bad dreams, being too warm, and family concerns. Review of the depression/anxiety care plan showed it was last updated on 1/22/14. The nurse's approach was dated 9/21/13 and showed they were to reinforce strengths, administer medications and evaluate the effectiveness and adverse effects. The approach dated 1/24/14 showed social services was to "provide emotional support meet with elder as needed to discuss concerns and mood." The care plan failed to include resident-specific information such as the identified triggers that caused the resident anxiety and depression. Further, the approaches were not individualized	F 279		

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535084	A. BUILDING _____ B. WING _____	C 10/22/2014

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 10 or developed to be meaningful in assisting the resident with his/her needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record and incident report review and staff interview, the facility failed to ensure staff reviewed and revised the care plan to accurately reflect the resident's status for 3 of 12 sample residents (#15, #47, #48). The findings were: 1. Review of the medical record showed resident #15 was admitted to the facility on 8/20/13 with	F 280	Green House Living for Sheridan will ensure all Elders have a Care Plan that accurately reflects their status. This will be accomplished by: 1. All incident reports will be sent to MDS Coordinator and Administrator immediately upon their completion through the EMR. MDS Coordinator will review the incident, update the care plan with the new interventions resulting from the post-fall huddle, and sign off on the incident report when completed. 2. DON will sign off on incident reports only after MDS Coordinator has reviewed them and updated the care plan. 3. Post-fall huddle recommendations have been added to the care plan of Elder # 15 on 11/13/2014. 4. All incident reports from Sept. to Nov., 2014, will be reviewed by the QA Mgr, DON and MDS Coord. and updated as necessary to reflect results of post-fall huddles. 5. Post-fall huddle recommendations have been added to the care plan of Elder # 47 on 11/13/2014. 6. Elder # 48 is no longer in the facility and was discharged on 04/30/2014.	12/5/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535064	A. BUILDING _____ B. WING _____	C 10/22/2014

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 280	Continued From page 11 diagnoses including Alzheimer's disease and gouty arthritis. According to the incident report the resident fell on 8/26/14 at 10:30 PM. The resident sustained a scrape to the left knee and complained of pain in the left shin. Review of the post-fall huddle notes revealed the resident should be encouraged to take his/her time and not to move too quickly when turning around. Review of the care plan dated 8/27/14 showed no evidence it was updated to include the post fall huddle team's recommendation. Interview with the DON on 10/22/14 at 11:55 AM verified the care plan was not updated to include the post fall huddle recommendation, but should have been. 2. Review of the 9/18/14 significant change MDS assessment showed resident #47 had diagnoses that included a history of hip fracture. Review of nursing notes dated 9/28/14, timed 11:06 PM, revealed the resident had fallen earlier that day. Review of the facility incident report dated 9/28/14, timed 11:04 PM, showed the resident had fallen while getting up from the dining room table. Review of the post-fall huddle showed the fall analysis determined the resident needed to use the bathroom after eating and was trying to do this while both Shahbazim were working in the kitchen. The post-fall huddle recommended "possibly have a CNA at the table helping elders with their needs while the other CNA is working in the kitchen allowing for full assistance to elder as needed." Review of the resident's care plan for falls revealed it was last updated on 9/19/14, was not updated after the resident's fall on 9/28/14, and did not include any recommendation for assisting the resident to the bathroom after meals. Interview with the DON on 10/22/14 at 11:55 AM verified the care plan was not updated to include the post fall huddle recommendation,	F 280	F 280 - Continued from above: 7. Incident reports will be reviewed at monthly Safety Committee meetings to establish sentinel events and trends. QA Manager will attend all Care Plan meetings to monitor for negative trends. Negative trends will be reported to QAPI committee.	

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 10/22/2014

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 280	Continued From page 12 but should have been. 3. Review of the 3/3/14 quarterly MDS assessment for resident #48 showed s/he did not have cognitive impairment and functioned independently in all activities of daily living. Review of the social services note, dated 2/27/14, showed the resident talked with the social worker about wanting to be discharged to another facility. Review of the care conferences, dated 3/17/14, 3/19/14 and 4/15/14 showed the social worker, DON and other department managers talked with the resident and his/her family about discharge plans for the resident. Review of the nurse's notes showed the resident was discharged on 4/30/14. However, review of the care plan showed it had not been revised to include discharge planning information. During an interview on 10/21/14 at 5:10 PM, the administrator, DON and social worker verified this information had not been included in the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow the care plan for 1 of 12 sample residents (#15). The findings were:	F 282	Green House Living for Sheridan will ensure that all staff provides care to the Elders according to their individualized care plan. This will be accomplished by: 1. In-service of all Shahbazim by 11/30/2014 regarding timely reporting of behaviors to the nurse. This will be done by the Guide and the DON. 2. Shahbazim will report to nurse on each shift clinical information and sign off on their shift report. Guide and DON will monitor shift reports to assure this communication is taking place.	12/5/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 282	Continued From page 13 Review of the medical record revealed resident #15 was admitted to the facility on 8/20/13 with diagnoses that included Alzheimer's disease and psychosexual disorder. Review of the Shahbazim notes dated 8/27/14 at 8:48 PM showed the resident was screaming and cursing at others which disrupted the living environment. Staff attempted to calm the resident by talking to the resident on a 1:1 level. Further review of these notes showed this approach "worsened" the resident's out of control behaviors and s/he began pacing, wandering, rummaging, and interfering with the care of other residents. Again, the staff attempted talking with the resident on a 1:1 basis which "worsened" the resident's behaviors and s/he started pushing and grabbing at other residents; placing them at risk. The staff attempted talking with the resident on a 1:1 basis which again "worsened" his/her behaviors. Review of the care plan, updated on 8/12/14, showed an intervention: "Report behaviors to nurse." However, review of the nursing notes dated 8/27/14 at 8:57 PM showed "BEHAVIOR: No behavior issues." Interview with the DON on 10/22/14 at 11:55 AM verified care plans should be followed and there was no evidence the behaviors noted on 8/27/14 by the Shahbazim were reported to the nurse as indicated on the care plan.	F 282	F 282 - Continued from above: 3. To ensure that Shahbazim remain current on Care Plan interventions, Care Coordinators in each cottage will systematically review care plans of those Elders scheduled for MDS review during their team meetings. 4. Social Worker and QA Coordinator will audit behavior charting for congruence. 5. Guide will notify QA Manager of any concerns regarding Shahbaz Care Plan review process. Any negative trends will be reported to the QAPI committee.	
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.	F 284	Green House Living for Sheridan will ensure a discharge plan is developed for Elders who are discharged. This will be accomplished by: 1. "Documentation of Transfer/Discharge" policy was updated on 11/14/2014.1. 2. When an Elder is identified as a potential for discharge or transfer, the Social Worker will update the Care Plan.	11/30/2014

PRINTED: 11/05/2014
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 10/22/2014

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 284	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to develop a discharge plan for 1 of 1 sample resident (#48) who was discharged from the facility. The findings were: Review of the 3/3/14 quarterly MDS assessment for resident #48 showed s/he did not have cognitive impairment and functioned independently in all activities of daily living. Further review of the MDS showed the resident did not have an interest in being discharged from the facility. However, review of the social services note, dated 2/27/14, showed the resident talked with the social worker about wanting to be discharged to another facility. Review of the care conferences, dated 3/17/14, 3/19/14 and 4/15/14 showed the social worker, DON and other department managers talked with the resident and his/her family about discharge plans. Review of the care plan showed the care plan had not been revised to include identified discharge needs and goals. Review of the policy and procedure titled, "Documentation for Transfers/Discharges," revised 7/15/14, showed the Care Planning Team were directed to document a summary of the resident's overall medical, physical, and mental condition as part of the discharge planning process. Review of the nurse's notes showed the resident was discharged on 4/30/14. During an interview on 10/21/14 at 5:10 PM, the administrator, DON and social worker verified the plans for the resident to be leave the facility had not been noted in the 3/3/14 MDS assessment and interventions related to discharge planning had not been	F 284	F284 - Continued from above: 3. Elder # 48 is no longer in the facility and was discharged on 04/30/2014. 4. Social Worker has identified a current Elder for potential discharge to the community and has updated the Care Plan accordingly. Discharge Plan is being developed as circumstances evolve. 5. Social Worker will report any negative trends to the QAPI Committee.	

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 284	Continued From page 15 included in the care plan. At that time they also stated the Care Planning Team did not document a summary as directed by the policy and procedure.	F 284		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and facility policy review, the facility lacked evidence nursing staff provided the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for 3 of 8 sample residents (#13, #26, #46) who had pain or discomfort. The findings were: 1. Review of the medical record showed resident #13 had diagnoses including chronic pain, autonomic neuropathy, restless leg syndrome and wrist drop. Review of the 9/17/14 annual MDS assessment showed the resident had frequent pain which made it hard to sleep. The resident identified his/her pain as 8 on a level of 0 to 10 with 10 being the worst (8/10). Review of the September 2014 physician orders showed the resident had an order for Tylenol 325 mg 2 tablets every 4 hours as needed for pain as well as Percocet 5 mg/325 mg 1 tablet every 4 hours as	F 309	Green House Living for Sheridan will ensure that all nursing staff provides the necessary assessments, monitoring, and nursing measures to ensure adequate pain management for all Elders. This will be accomplished by: 1. Nursing in-service on 11/12/2014 regarding pain management. Topics covered: a. Reassessment of pain no later than 2 hours after receiving pain medication. Consensus of nurses was to reassess closer to ½ to 1 hour. b. Elders with pain as a problem on their care plan will have specific parameters for acceptable level of pain. c. Pain management must be reassessed whether or not alarms in the EMR are working. 2. Elder # 13 has an acceptable level of pain of 4 on a scale of 0-10 on his Care Plan after speaking with the MDS Coordinator on 11/13/2014. His acceptable reasonable time of achieving that pain control is one hour. 3. Elder # 26 had pain assessment updated 11/13/2014 and care plan has been updated to reflect the findings of the assessment.	11/30/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 309	Continued From page 16 needed for pain. The following concerns with pain management were identified: a. Review of the nursing notes dated 10/5/14 and timed at 8:26 PM showed the resident was administered Percocet 1 tablet for foot pain rated at 5/10. Review of the re-assessment showed it was not performed until 11:47 PM (3 hours and 21 minutes later). b. Review of the nursing notes dated 10/6/14 and timed at 12:51 PM showed the resident received Percocet 1 tablet for pain rated at 8/10 in both legs. Further review of the nursing notes showed the resident's pain was not re-assessed until 3:24 PM, two and one-half hours later. Review of additional nursing notes dated 10/6/14, timed at 10:31 PM, revealed the resident had foot and leg pain rated at 4/10. The resident was administered Percocet 1 tablet. There was no evidence the resident was re-assessed to determine the effectiveness of the medication in relieving his/her pain. c. Review of the 10/10/14 nursing notes timed at 8:19 PM showed the resident was administered Percocet 1 tablet for pain rated 6/10 in his/her legs. The resident's pain was not re-assessed until 11:34 PM (3 hours 15 minutes later). d. Review of the 10/14/14 nursing notes timed at 5:29 PM showed the resident was administered Percocet 1 tablet for pain. Further review showed the resident's pain was not re-assessed to determine the effectiveness of the pain medication in relieving his/her pain until 3 hours later, at 8:28 PM. e. Review of the 10/17/14 nursing notes timed at 8:30 PM showed the resident received Percocet 1 tablet for pain rated at 3-7/10 in the right ankle. Further review showed the resident's pain was not re-assessed to determine	F 309	F 309 - Continued from above: 4. Following current policy and procedure, Elder # 46 will be appropriately reassessed after administration of pain medication. 5. MDS Coordinator will review Care Plans of Elders who have pain as a problem and delincate specific parameters for pain management on the Care Plan. 6. DON will monitor 24-hour report tool in EMR daily for follow-up of PRN pain medications and usage trends and report to QAPI Committee any negative trends.	

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 10/22/2014

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 309	Continued From page 17 effectiveness of the Percocet until the following morning, 10/18/14, at 12:50 AM (4 hours 20 minutes later). f. Review of the 10/18/14 nursing notes timed at 7:42 PM showed the resident was administered Percocet for pain rated 6/10 in the right ankle and foot. Review further showed the pain re-assessment was not performed until 11:38 PM (4 hours later). g. Review of the 9/17/14 care plan showed the goal was "Expressed feelings of comfort or of pain relief within reasonable time after pain med administration, Says pain meds are effective." However, no acceptable level of pain was identified for this resident and "reasonable time" was not defined. In addition, the nursing approaches were not individualized for this resident. Approaches included "Assess physical symptoms Anticipate pain and treat Assess attitudes regarding pain Ask about pain regularly Use verbal pain assessment tool Use non-verbal assessment tool Administer pain meds and note effectiveness/adverse effects Encourage exercise Notify physician of changes Educate regarding pain medications." Review of the care plan showed no evidence parameters or measurements were identified to determine the effectiveness of pain management. h. Review of the facility's policy and procedure on pain management, reviewed November 2013, showed "...goals will be specifically defined and documented...Implement the medication regimen as ordered, carefully documenting the results of the interventions.." i. Interview with the DON on 10/22/14 at 11:55 AM revealed her expectation was that a pain re-assessment would be performed no more than 2 hours after administration of a pain medication.	F 309		

PRINTED: 11/05/2014
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 10/22/2014

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 309	Continued From page 18	F 309		

2. Review of the medical record showed resident #26 had orders for scheduled Tylenol three times per day, PRN Tylenol, and a Salonpas patch (Camphor-Menthol-Menthyl salycilate patch) for pain. The documentation for the administration and effectiveness of the PRN medications were found in the nurses notes. Review of the September and October 2014 notes showed the resident received the pain patch 7 times, and 3 of the 7 times, the patch was shown to be ineffective for treatment of the resident's pain. The following concerns were identified:

a. On 9/1/14 at 9:36 PM the patch was applied for reported back pain with a 6/10 rating. At 9:37 PM the effectiveness was documented as "Ineffective but left patches in place, hoping for some relief." Review of the notes showed no further evaluation of the resident's pain on 9/1/14.

b. On 10/10/14 at 9:45 AM the patch was applied for "back pain." There was no pain scale documented. At 12:40 PM (2 hours and 55 minutes later) the nurse documented "Med [medication] ineffective elder continues to c/o [complain of] pain." The 12:41 PM note showed scheduled Tylenol was given at that time; however, there was no re-evaluation of the resident's pain for the remainder of 10/10/14.

c. On 10/12/14 at 3:40 PM the pain patch was applied due to complaints of pain in the lower back rated at 7/10. At 5:46 PM the nurse noted the medication was ineffective and the resident's pain level after the medication remained at 7/10. The note failed to include any alternatives tried at that time. At 9:32 PM (3 hours and 46 minutes later) the nurse's note showed the resident complained of pain in the lower back and a Salonpas patch was applied until shower. After the shower "biofreeze" (a topical pain reliever)

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 10/22/2014

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 309	Continued From page 19 was applied. There were no further nurses notes for 10/12/14 to show if the resident received any relief from the pain medications/treatments. 3. Review of the medical record showed resident #46 had diagnoses including moderate to severe pain due to a hip fracture that occurred in March 2014. Review of the 9/3/14 quarterly MDS assessment showed the resident had frequent pain that affected sleep. This review showed the resident identified his/her pain as 8 on a level of 0 to 10. Review of the September 2014 physician orders showed Fentanyl 50 mcg patch (a transdermal pain medication) every 72 hours and Norco 5/325 mg, 1 or 2 tabs, every 4 hours as needed were ordered for pain. The following concerns regarding pain management were identified: a. Review of the 10/3/14 nursing notes, timed at 4:49 PM, showed the resident received 2 Norco pills for "pain/discomfort". This review also showed the resident was unable to verbalize the location of the pain and the severity of the pain when the medication was administered. Further review revealed the resident was not re-assessed for effective pain management until 9:21 PM (4 hours and 20 minutes later). b. Review of the 10/9/14 nursing notes, timed at 12:44 PM, revealed the resident received two Norco pills for back and hip pain rated at 4. This review also showed no evidence the resident was re-assessed to determine the effectiveness of the medication in relieving his/her pain. c. Review of the 10/17/14 nursing notes, timed at 5:37 AM, showed the resident received 2 Norco pills for pain radiating from the hip and rated at 8. This review also showed the resident was not re-assessed for effective pain management until 9:39 AM (4 hours later).	F 309		

PRINTED: 11/06/2014
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 10/22/2014

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 309	Continued From page 20 d. Review of the 10/17/14 nursing notes, timed at 6:35 PM showed the resident received 2 Norco pills for pain in both legs rated at 7. This review also showed no evidence the resident was re-assessed to determine the effectiveness of the medication in relieving his/her pain.	F 309		
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 medical record and incident report review and resident and staff interview, the facility failed to ensure incidents of falls were evaluated and analyzed in order to develop meaningful interventions to minimize accidents for 3 of 7 sample residents (#15, #26, #47) who had falls. The findings were: 1. Review of the medical record showed resident #15 was admitted to the facility on 8/20/13 with diagnoses including Alzheimer's disease and gouty arthritis. Review of the 8/3/14 annual and the 10/21/14 quarterly MDS assessments showed the resident required supervision with walking in the room and in the corridor, and when on and off the unit. Review of these MDS assessments also showed the resident wandered daily. Review of incident reports showed this resident had a fall on	F 323	Green House Living for Sheridan will ensure that all incidents of falls are evaluated and analyzed in order to develop meaningful interventions to minimize accidents. This will be accomplished by: 1. Nursing staff in-service regarding expectations of the post-fall huddle was completed on 11/12/2014. The process of Root-Cause Analysis was reviewed. 2. All incident reports will be sent to MDS Coordinator and Administrator immediately upon their completion within the EMR. MDS Coordinator will review the incident, update the care plan with the new interventions resulting from the post-fall huddle, and sign off on the incident report when completed. 3. DON will sign off on incident reports only after MDS Coordinator has reviewed them and updated the care plan. 4. Safety Committee will review all fall incidents at monthly meeting for sentinel events and trends. 5. Shahbazim will review falls that occurred in their specific cottages at their monthly team meetings for familiarity with incidents. 6. Safety Committee will report findings of falls review at QAPI meetings.	12/4/2014

PRINTED: 11/05/2014
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 10/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	3311 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 21 1/3/14 where s/he turned around quickly and lost his/her balance. Another fall occurred on 2/2/14 when the resident tripped on the transition strip between the carpet and hardwood floors. Review of incident reports showed the resident fell on the back patio on 5/19/14 at 4:33 PM and sustained a skin tear to the right hand and a scrape to the right knee. Further review of incident reports showed the resident fell again on 8/26/14 at 10:30 PM, sustained a scrape to the left knee and complained of pain in the left shin. The following concerns with fall prevention for this resident were identified: a. Review of the 5/19/14 incident report showed no staff were with the resident or within eyesight of his/her ambulation. The fall was not witnessed. According to the incident report, the "Elder ambulated into cottage from back patio and stated, 'I fell down.'" Interview with the DON on 10/22/14 verified there was no evidence the resident was supervised while outside on the patio. The resident experienced another fall on 10/2/14 when s/he fell while not being supervised or within eyesight of staff. The post-fall huddle recommendation included the resident should be watched more intently, staff should walk with the resident to his/her room, offer toileting and then assure the resident gets into bed safely. b. Review of incident reports showed the resident fell again on 8/26/14 at 10:30 PM. The resident sustained a scrape to the left knee and complained of pain in the left shin. Review of the post-fall huddle notes showed the resident was encouraged to take his/her time and not to move too quickly with turns. Review of the 1/3/14 incident report showed the resident had fallen due to moving and turning too quickly as well. However, review of the care plan dated 8/27/14 showed no evidence it was updated to include the	F 323	F 323-Continued from above: 7. The care plan for Elder #15 has been reviewed and updated for current fall precautions. 8. The care plan for Elder #26 has been reviewed and updated for current fall precautions. 9. The care plan for Elder #47 has been reviewed and updated for current fall precautions. 10. DON and QA Coordinator will review all Incident Reports from September 1, 2014 to the present to assure that meaningful interventions have migrated to the Care Plan.	

PRINTED: 11/05/2014
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 10/22/2014

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 22 post-fall huddle team's recommendation nor was the resident's history of turning rapidly included on the care plan. Interview with the DON on 10/22/14 at 11:55 AM verified the care plan was not updated to include the post-fall huddle recommendation. 2. Review of the 9/18/14 significant change MDS assessment showed resident #47 had diagnoses that included a history of hip fracture, and had a BIMS score of 13 (indicating intact cognition). Interview with the resident on 10/19/14 at 4 PM revealed the resident had suffered a fall recently that resulted in a collapsed lung. According to the resident, s/he was ambulating to the bathroom in his/her bedroom without the assistance of a walker, and tripped over the threshold between the bedroom and bathroom. The following concerns were identified: a. Review of the facility's incident report of that fall, dated 7/28/14, showed the resident was "found down" in his/her room, had a scrape and edema to the right mid back, and complained of pain to the right mid back. The report further showed the resident was transferred to the emergency room. The report failed to show any analysis of the fall cause. The possible cause of the fall was noted as "found down." b. There was no post-fall huddle documented, and no recommendations for fall prevention made. c. Review of nursing notes dated 9/28/14, timed 11:06 PM, showed the resident suffered another fall. No injuries were sustained from this fall. d. Review of the resident's care plan for falls showed it was last updated with fall interventions on 7/3/14.	F 323		

PRINTED: 11/05/2014
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
	835054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 23 3. Interview with resident #26 on 10/20/14 at 9:50 AM revealed s/he could not see well due to macular degeneration. Observation at that time revealed the resident ambulated without assistance. In the resident's room there was a walking cane, and when asked about the assistive device, the resident stated s/he had a fall, and now used it when getting up in the night. The following concerns were identified: a. Random observations on 10/20/14 and 10/21/14 showed the resident did not use the cane while ambulating in the hallways. b. Review of the medical record showed the resident had unwitnessed falls on 5/10/14 and on 7/9/14. According to the nursing incident notes the resident was found on the floor in his/her room, and there were no apparent injuries from either fall. However, the notes for these falls failed to include any evaluation and analysis related to how the fall happened and possible interventions to prevent future occurrences. In addition, review of the care plan related to falls showed the most recent update was 7/7/14, the cane was not addressed and there were no new approaches or evidence the care plan was reviewed after the last fall. 4. Interview with the DON on 10/21/14 at 9 AM revealed the facility "knew falls have been a problem." 5. Review of the facility's policy and procedure on falls, revised July 2014, showed instructions for staff, with the input of the attending physician, to identify appropriate interventions to reduce the risks of falls based on the fall risk assessment. "If falling recurs despite interventions, the staff will implement additional or different interventions or indicate why the current approach remains	F 323		

PRINTED: 11/05/2014
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
	536054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 24 relevant. Interventions will continue until falling is reduced or stopped, or the reason for the continuation of falling is identified as unavoidable. The staff will monitor and the nurse will document each Elder's response to interventions intended to reduce falling or the risks of falling."	F 323		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	Green House Living for Sheridan will ensure that required nurse staffing data is posted on a daily basis, at the beginning of each shift. This will be accomplished by: 1. Facility name; current date; total number and actual hours worked for registered nurses, licensed practical nurses, and certified nurse aides; and resident census will be written on a piece of paper posted in the common area of each cottage. This area is readily accessible to Elders and visitors. 2. Staff will be in-serviced on posting required nurse staffing data and resident census by 12/5/14. 3. The Guide's checklist for regularly scheduled walk-throughs was amended to include posted nurse staffing data requirements and resident census. Immediate corrective action will be taken if required. 4. The Guide will report negative trends to the QAPI Committee. 5. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months.	12/5/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 356	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post, on a daily basis, the total number of and actual hours worked by RNs, LPNs and CNAs (Shahbazim), and the resident census. The findings were: Periodic observation from 10/19/14 through 10/22/14 failed to reveal posted nurse staffing and resident census. Interview with the facility administrator on 10/22/14 at 3:03 PM confirmed the facility was not posting nurse staffing and resident census as required.	F 356		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to assure medical	F 514	Green House Living for Sheridan will ensure that medical record notations are consistent between caregivers. This will be accomplished by: 1. In-service of all Shahbazim by 11/30/2014 regarding reportable behaviors. This will be done by the Guide and the DON. 2. Nurses will meet with Shahbazim before the end of each shift to exchange information that may not have been relayed earlier in the day. 3. After Shahbazim have reported to the nurse toward the conclusion of their shift, they will initial the Shahbaz Shift Report Book. 4. Negative trends will be reported to the QAPI Committee for corrective action. 5. The Guide will audit the Shahbaz Shift Report Book ~~on a daily~~ for completeness on a daily basis and will follow up on any omissions with pertinent staff.	12/5/2014

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

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 10/22/2014

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 514	Continued From page 26 record notations were consistent between caregivers for 1 of 12 sample residents (#15). The findings were: Review of the medical record revealed resident #15 was admitted to the facility on 8/20/13 with diagnoses that included Alzheimer's disease and psychosexual disorder. Review of the Shahbazim notes dated 8/27/14 at 6:48 PM showed the resident was screaming and cursing at others which disrupted the living environment. Staff attempted to calm the resident by talking to the resident on a 1:1 level. Further review of these notes showed this approach "worsened" the resident's out of control behaviors and s/he began pacing, wandering, rummaging, and interfering with the care of other residents. Again, the staff attempted talking with the resident on a 1:1 basis which "worsened" the resident's behaviors and s/he started pushing and grabbing at other residents, placing them at risk. The staff attempted talking with the resident on a 1:1 basis which again "worsened" his/her behaviors. Review of the care plan, updated on 8/12/14, showed an intervention included "Report behaviors to nurse." However, review of the nursing notes dated 8/27/14 at 6:57 PM showed "BEHAVIOR: No behavior issues." Interview with the DON on 10/22/14 at 11:55 AM verified there should not be inconsistencies between the nursing notes and notes written by the Shahbazim. If the nurse is not in the building at the time of the incident or situation, the nurse should be notified upon her return to the cottage.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 27 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the CMS-2567 (Centers for Medicare and Medicaid Statement of Deficiencies), the facility failed to ensure the quality assessment and assurance committee was effective in resolving identified concerns. The findings were: Interview with the quality assurance coordinator on 10/21/14 at 2 PM revealed the facility was in the process of implementing a new program which would incorporate the PDSA (Plan, Do, Study, Assess) system. She stated the committee	F 520	Green House Living for Sheridan will maintain an effective quality assessment and assurance committee. This will be accomplished by: 1. The QAPI Committee meets quarterly to identify necessary quality assessment and assurance activities including quality deficiencies, and develop and implement appropriate plans of action. 2. Deficiencies cited at F279 and F323 are included in this plan of correction (above). 3. The QA Manager will review all care plans quarterly for quality assurance issues including individualization. Negative trends will be reported to the QAPI Committee for further action. 4. Safety Committee will meet on 11/20/14 to review incident reports and environmental hazards, among other safety practices, to identify sentinel events and trends. Corrective actions are generated at these meetings. Negative trends will be reported to the QAPI Committee for further action. 5. The QAPI Committee meets quarterly and reviews and corrects identified quality assurance issues. Based on the reourrence of F279 and F323, the Committee will focus on care plans and safety, among other topics. 6. The Medical Director will attend quarterly QAPI Committee meetings beginning at the next quarterly meeting on 01/19/2015.	11/20/14

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536054	A. BUILDING _____ B. WING _____	C 10/22/2014

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 28 meets quarterly with PIP (performance Improvement Projects) as needed. However, the following concerns were identified: a. Review of the CMS-2567 for last year's survey, dated 6/27/13 revealed the following deficiencies were written: F279 failure to develop individualized care plans, F323 failure to provide supervision to prevent accidents (falls) and F520 quality assessment and assurance. F279 and F323 were also cited during the survey completed in 2012. These same deficiencies are again being cited during the 2014 survey. The citations F279 and F323 have been identified problems for three years without sustained compliance. b. Interview with the quality assurance coordinator on 10/21/14 at 2 PM revealed the physician member was the medical director and he had never attended a meeting. Interview with the DON on 10/22/14 at 3:10 PM also verified the physician member had never attended the meetings.	F 520		