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

PRINTED: 01/19/2016
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 ______	12/03/2015

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 A recertification survey was conducted by Healthcare Licensing and Surveys on 11/30/15 through 12/3/15. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CAA: Care Area Assessment DON: Director of Nursing LPN: Licensed Practical Nurse RN: Registered Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator 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).	F 157	Green House Living for Sheridan (GHLS) will ensure that physicians are notified of any change of condition in their residents. This will be accomplished by: 1. Physician has been notified of Elder #2's current wounds. Continued Next Page	12/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski
TITLE: Administrator
(X6) DATE: 1/21/16

Changes made per phone call with Chris Szymanski, NHA on 1/27/16 @ 1:45 pm. POC accepted. Janice Cole, 2/9/16

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a 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 3 sample residents (#2) with a change in condition. The findings were: Review of the medical record showed resident #2 had diagnoses that included Parkinson's disease and diabetes mellitus. The 8/3/15 nurse's note timed at 10:29 PM showed the resident had a "healing sore on the coccyx 0.5 cm in diameter that is open with no s/s [signs/symptoms] of infection. Clean coccyx dressing applied." The 9/4/15 nurse's note timed at 3:28 AM showed "open area on coccyx now healed." On 10/19/15 a nurse's note timed at 9:16 PM showed the resident had an "open blister-like area" above the coccyx. Review of the 11/30/15, timed at 9:32 AM weekly skin assessment showed the resident had "2 pus filled type lesions to [his/her] right foot great toes and 2nd toe." Further review of the electronic and the hard copied medical record	F 157	Continued F-157: 2. Flowsheet has been developed by DON and MDS Coordinator which outlines steps to be taken for all new skin/wound issues, including notification of physician. The hard copy of this document will be placed in the chart upon its completion. This will be implemented beginning 12-30-2015. All nursing staff will be notified individually by DON no later than 12-30-2015. 3. DON will monitor 24-hour report daily for evidence of wounds and ensure that the flowsheet has been initiated and completed. Compliance will be monitored by the QA Committee and any negative trends will be reported by the DON.	12/30/2015

No pages 1-3

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F 157	Continued From page 2 failed to show the physician was notified of these changes in skin condition. Interview with the DON on 12/3/15 at 12:35 PM verified the physician should have been notified.	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 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	F 225	GHLS will ensure that an investigation will be completed on all Elders with injuries of unknown origin. This will be accomplished by: 1. DON in-serviced all nursing staff 12-16-15 at staff meeting regarding requirements and procedures when injuries of unknown origin are found. GHLS Abuse Investigation Policy was distributed at that meeting. a. According to F225, interpretive guidelines 483.13 (c) (1) (ii)-(iii), (c)(2)-(4): "Injury of unknown source" is defined as an injury that meets both of the following conditions: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the Elder; and 2) The injury is suspicious because of: (a) the extent of the injury; or (b) the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); or (c) the number of injuries observed at one particular point in time; or (d) the incidence of injuries over time Continued On Next Page	01/15/2016 12/16/2015

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F 225	Continued From page 3 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 review of facility investigations, policies and procedures, medical record review, and staff interview, the facility failed to ensure investigations were completed for 1 of 2 residents with injuries of unknown origin (#25). The findings were: Review of the 10/12/15 annual MDS assessment showed resident #25 had senile dementia, moderate to severe pain, used a wheelchair for mobility, and required extensive assistance with most ADLs. Review of the November 2015 cognitive monthly summary showed the resident had memory problems and was "occasionally combative during cares/ADLs." Review of the October 2015 to November 2015 nurse's notes showed a 3 centimeter circular bruise on the resident's outer right forearm was first identified on 10/27/15. This review showed the DON and physician were notified and the bruised area was dark purple on 10/30/15 and 10/31/15. Further review of the nursing notes showed that area was fading on 11/14/15; then 10 days later, two purple 2 centimeter circular bruises were noted on the dorsal side of the resident's right forearm on 11/24/15. Review of the 2015 facility investigations revealed no evidence the bruises on the resident's arm had been investigated. Interview with the DON on 12/2/15 at 10:15 AM verified an investigation had	F 225	Continued F225: 2. SDC will in-service all Shahbazim at their team meetings regarding P&P on Elder abuse and injuries of unknown source, including personnel to be notified. In-services will be completed by 1-15-2016. 3. Safety Committee will review all incidences where there was an injury of unknown source and report to QA Committee quarterly. Facility will do an investigation for injuries of unknown origin for Elder #25. JE	01/15/2016

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F 225	Continued From page 4 not been done. At that time she stated the resident had injuries of unknown origin and according to the facility's policy, staff were required to complete an investigation of both incidents. Review of the Abuse Investigations Policy, dated December 2011, showed, "Should an incident or suspected incident of Elder abuse, mistreatment, neglect or injury of unknown source be reported, the Guide, or his/her designee, will appoint a member of management to investigate the alleged incident."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure dignity for 2 of 5 sample residents (#9, #20) during care observations. The findings were: 1. Observation of care for resident #9 on 12/1/15 beginning at 1:36 PM showed Shahbaz #1 and Shahbaz #2 entered the resident's room to assist the resident with personal care that included catheter care, colostomy care, and changing the resident's brief, which exposed the resident. During the care provided, the window blinds and the door to the room were not closed. 2. Observation of care for resident #20 on 12/2/15 beginning at 3:13 PM showed Shahbaz #3	F 241	GHLS will ensure that all Elders are cared for in an environment that maintains or enhances each Elder's dignity and respect during personal cares and during treatment procedures. This will be accomplished by: 1. SDC will in-service all Shahbazim regarding each Elder's right to dignity and respect from direct care staff, with emphasis on ensuring doors are closed and blinds are closed before performing cares for an Elder, whether in their bedroom or bathroom. This will be completed by January 15, 2016 during team meetings. 2. The GHLS Guide will monitor compliance during daily walk-throughs in the cottages. Negative trends will be reported to QA Committee.	01/15/2016

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F 241	Continued From page 5 entered the resident's room with a mechanical lift and transferred the resident into the bathroom. During the transfer, the window blinds and door to the room were not closed. 3. Interview with the DON on 12/3/15 at 10:30 AM revealed the doors and blinds should be closed and the resident should be provided privacy during care. 4. Review of the policy titled "Quality of Life-Dignity" revised on 10/1/15 showed "...10. Staff shall promote, maintain and protect Elder privacy, including privacy during assistance with personal care and during treatment procedures..."	F 241		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272	GHLS will ensure that all Elders have a comprehensive assessment, including analysis of the data, completed as required by the State. This will be accomplished by: 1. DoN and MDS Coordinator contacted ECS clinical support on 12-17-2015 regarding clarification of requirements for summary statement and how the ECS charting fulfills those requirements. All elements required by CMS are present in our software to generate the summary statement. 2. DoN and MDS Coordinator watched ECS training video on 12-17-2015 entitled "CAAs Completion and Editing" which elaborated on the documentation of summary information. Elders #2, #6, #9, #20, #23, #27, #27, #31, #40, #44, and #45 have had Comprehensive Assessments Completed.	12/17/2015

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F 272	Continued From page 6 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 11 of 11 sample residents (#2, #6, #9, #20, #23, #25, #27, #31, #40, #44, #45). The findings were: 1. Review of the 9/3/15 significant change MDS assessment for resident #2 showed the following areas triggered which required a comprehensive assessment: cognitive loss/dementia, visual function, communication, ADL function, urinary incontinence, falls, nutrition, pressure ulcers, psychotropic medication use, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 2. Review of the 11/23/15 annual MDS	F 272	the DON and MDS coordinator meet on a weekly basis to review relevant Comprehensive assessments, and report negative findings to the QA committee	

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F 272	Continued From page 7 assessment for resident #6 showed the following areas triggered which required a comprehensive assessment: delirium, cognitive loss/dementia,visual function, communication, falls, psychotropic medication use, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 3. Review of the 8/31/15 annual MDS assessment for resident #40 showed the following areas triggered which required a comprehensive assessment: cognitive loss/dementia, ADL function, urinary incontinence, falls, nutrition, pressure ulcers, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 4. Review of the 9/3/15 annual MDS assessment for resident #44 showed the following areas triggered which required a comprehensive assessment: delirium, cognitive loss/dementia, communication, urinary incontinence, psychosocial well-being, falls, nutrition, dental care, pressure ulcers, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 5. Review of the 5/5/15 admission MDS assessment for resident #31 showed the following areas triggered which required a comprehensive assessment: cognitive loss/dementia, visual function, communication, ADL function, urinary incontinence, falls, nutrition, dental care, pressure ulcers, psychotropic	F 272		

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F 272	Continued From page 8 medication use, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 6. Review of the 6/22/15 annual MDS assessment for resident #9 showed the following areas triggered which required a comprehensive assessment: visual function, communication, urinary incontinence/catheter, falls, nutritional status, dehydration/fluid maintenance, and pressure ulcers. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 7. Review of the 9/21/15 admission MDS assessment for resident #20 showed the following areas triggered which required a comprehensive assessment: cognitive loss, communication, ADL function/rehabilitation potential, urinary incontinence/catheter, psychosocial well being, mood state, activities, falls, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcers, and psychotropic drug use. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 8. Review of the 8/10/15 significant change MDS assessment for resident #23 showed the following areas triggered which required a comprehensive assessment: visual function, ADL function/rehabilitation potential, urinary incontinence/catheter, falls, dehydration/fluid maintenance, pressure ulcers, psychotropic drug use, and pain. Review of the CAAs for these triggered areas showed they were incomplete and	F 272		

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F 272	Continued From page 9 lacking an analysis of the data to support the care plan decision. 9.Review of the 10/12/15 annual MDS assessment for resident #25 revealed the following areas triggered and required comprehensive assessments: cognitive loss, visual function, communication, urinary incontinence, psychosocial well-being, dehydration, pressure sores, and pain. Review of the assessment of the triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 10. Review of the 10/6/15 significant change MDS assessment for resident #27 showed the following areas triggered which required a comprehensive assessment: delirium, cognitive loss, communication, urinary incontinence/catheter, falls, nutritional status, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 11. Review of the 1/15/15 admission MDS assessment for resident #45 showed the following areas triggered which required a comprehensive assessment: ADL function/rehabilitation potential, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis of the data to support the care plan decision. 12. Interview with the DON and the MDS coordinator on 12/1/15 at 11:20 AM revealed the	F 272		

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F 272	Continued From page 10 CAAs did not include an analysis of the information prior to developing the care plans.	F 272		
F 280 SS=E	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: 3. Review of the medical record showed resident #2 had diagnoses that included Parkinson's disease and diabetes mellitus. The 8/3/15 nurse's note timed at 10:29 PM showed the resident had a "healing sore on the coccyx 0.5 cm in diameter that is open with no s/s [signs/symptoms] of infection. Clean coccyx dressing applied." The 9/4/15 nurse's note timed at 3:28 AM showed "open area on coccyx now healed." On 10/19/15	F 280	GHLS will ensure that all Elders have a Care Plan that accurately reflects their current status. This will be accomplished by: 1. Elder #2 has a revised Care Plan that includes his history of open areas to the coccyx and his history of wearing shoes to bed, which could potentially cause blisters to his feet. 2. Elder #40 has a revised Care Plan that includes specific information regarding incontinence, including the type of absorbent used and the amount of fluids to be encouraged. 3. Elder #20 has a revised Care Plan that includes the use of a foot-cradle on her bed and pillows for floating heels while in bed. Heel blister has healed. 4. Elder #9 has colostomy care added to his Care Plan. 5. DON, MDS Coordinator, and SDC will meet monthly with team leader (Shahbaz) from each cottage to review and update Care Plans. 6. MDS Coordinator and SDC will meet twice weekly observe cares in each cottage to capture specialized treatments for each Elder and ensure they are added to the Care Plan. Continued Next Page	01/15/2016

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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 a nurse's note timed at 9:16 PM showed the resident had an "open blister-like area" above the coccyx. Review of the 11/30/15 timed at 9:32 AM weekly skin assessment showed the resident had "2 pus filled type lesions to [his/her] right foot great toes and 2nd toe." Interview with Shahbaz #4 on 12/3/15 at 9:35 AM revealed the resident often wore slipper shoes to bed, and this was something they were trying to avoid. Review of the Impaired skin integrity care plan showed the resident was at risk for developing skin breakdown. On 11/27/15 the problem was updated to include high risk for heel ulcer. The risk was related to limited mobility, urinary incontinence, diabetes, poor nutritional status, and disease process. The care plan failed to include the resident had a history of open areas to the coccyx. In addition, the care plan failed to address the resident was known to wear shoes to bed prior to the development of the lesions on his/her toes. 4. Review of the care plan for resident #40 showed the resident had problems identified that included urinary incontinence. The incontinence care plan was initiated on 12/29/14 and included the following nursing interventions: "address underlying causes...assure adequate fluid intake...assess for appropriate absorbent product." The interventions shown for the shahbazim included "use absorbent product, cleanse peri area and apply barrier cream after incontinent episodes...look for wet clothing [the resident] may have hidden in [his/her] room ...bathroom sensor to alert staff to toileting and clothes changes." The interventions failed to include specific information related to the resident's needs such as a toileting time frame or program for prompted voiding, the amount of	F 280	Continued F-280: 7. MDS Coordinator will review Dr. Orders daily on each Elder for new treatments and update the Care Plans accordingly. 8. DON will audit Care Plans systematically according to the MDS schedule to ensure all areas have been individualized. DON will report any negative trends to QA Committee.	

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F 280	Continued From page 12 fluids the resident needed, and the type of absorbent product the resident used. Based on observation, medical record review, and staff interview, the facility failed to ensure the care plan was revised to reflect the resident's current status for 4 of 11 sample residents (#2, #9, #20, #40). The findings were: 1. Observation on 12/2/15 at 2:25 PM showed RN #1 changed the wound dressing for resident #20. The wound was located on the left heel and measured 4 cm (centimeters) by 3.5 cm. A foam heel dressing was applied. Further, the resident's heels were elevated with a pillow and a sheet lifting device was applied to the foot of the bed. The following concerns were identified: a. Review of the pressure ulcer care plan revised on 10/6/15 showed the resident was at a low risk for skin breakdown and there was no evidence of an actual pressure ulcer on the care plan. Further, the wound dressing and sheet lifting device were not included as pressure relief interventions. b. Interview with the DON and MDS Coordinator on 12/3/15 at 11 AM confirmed the resident had a pressure ulcer and revealed the interventions should have been on the care plan. 2. Observation on 12/1/15 at 1:36 PM showed Shahbaz #1 assisted resident #9 with care of a colostomy by removing the bag and cleaning the stoma. The staff member emptied the colostomy bag, cleaned it, and reapplied it to the resident.	F 280		

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F 280	Continued From page 13 The following concerns were identified: a. Review of the ADLs/Functional care plan evaluated on 9/30/15 showed the resident had a self care deficit; however, the colostomy and colostomy care were not identified on the care plan.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to effectively assess and monitor pressure ulcers for 2 of 2 sample residents (#2, #20) with pressure ulcers. The findings were: 1. Review of the medical record showed resident #2 had diagnoses that included Parkinson's disease and diabetes mellitus. The 8/3/15 nurse's note timed at 10:29 PM showed the resident had a "healing sore on the coccyx 0.5 cm in diameter that is open with no s/s [signs/symptoms] of infection. Clean coccyx dressing applied." The 9/4/15 nurse's note timed at 3:28 AM showed "open area on coccyx now healed." On 10/19/15 a nurse's note timed at 9:16 PM showed the	F 314	GHLS will ensure that all wounds/pressure ulcers will be effectively assessed and monitored. This will be accomplished by: 1. Physician has been notified of the wounds for Elder #2. The Care Plan has been revised to include his history of open areas to the coccyx and his history of wearing shoes to bed, which could potentially cause blisters to his feet. Blisters to toes have been healed. Open area to coccyx is healed, though still monitored for potential breakdown. 2. Heel wound on Elder #20 was assessed and found to be healed on 12-18-2015. 3. GHLS will designate one R.N. by 12-30-2015 to perform all wound assessments to ensure consistency in measuring, treatment planning, and on-going monitoring. 4. Skin / Wound Flow-Sheet for Initiation of Care has been developed and will be used by nurses when any wound is first identified. Flow sheet will ensure that all wounds are assessed and measured on a weekly basis until healed. Monitoring will be completed by R.N. designated above. Continued Next Page	01/15/2016 12/18/2015 12/30/2015

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F 314	Continued From page 14 resident had an "open blister-like area" above the coccyx. Review of the 11/30/15 timed at 9:32 AM weekly skin assessment showed the resident had "2 pus filled type lesions to [his/her] right foot great toes and 2nd toe." The following concerns were identified: a. Review of the medical record failed to show any physician notification of these ulcers/lesions. The 1/26/15 signed standing physician orders related to skin care showed wounds were to be cultured for signs and symptoms of infection, and for a "Pressure wound" there was to be a "wound team consult" and additional calories and protein for wound healing. There was no standing order for the type of dressing to be used. b. Review of the nurse's notes failed to show any measurements or further assessment of the wound identified on 10/19/15. The weekly skin assessment on 10/26/15 at 9:01 PM, showed there was a dressing to the coccyx which was clean dry and intact. The 11/2/15 weekly skin assessment did not address the area, and the 11/9/15 timed at 1:51 AM "skin monthly summary" failed to address the area. c. Observation on 12/2/15 at 10:20 AM showed the resident was laying in bed with slippers on. RN #2 removed the residents slipper and sock and exposed dressings on the resident's right great toe and 2nd toe. The dressings were removed and exposed a blanchable red area to both toes. The nurse explained to the resident that the skin appeared "fragile" and she would apply new dressing because it appeared there were "blisters" that had opened and re-absorbed. d. The 2 lesions on the resident's toes were identified on 11/30/15; however, the assessment was completed on 12/2/15 at 2:59 PM. Interview	F 314	Continued F-314: 5. DoN, MDS Coordinator and R.N. designated for wound care will meet on a weekly basis to discuss progress of those Elders with wounds. Pressure ulcers and other wounds will be reported to the QA Committee and monitored for negative trends.	

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F 314	Continued From page 15 with the DON on 12/2/15 at 9:50 AM verified she was not previously aware of the skin lesions to the resident's toes. e. Interview with the DON on 12/3/15 at 12:35 PM verified there were no orders for wound treatments other than the standing orders from the resident's physician. 2. Medical record review showed resident #20 was admitted to the facility on 12/1/14 with diagnoses which included manic depression and senile delusion. Review of the 9/21/15 quarterly MDS assessment showed the resident was not at risk for pressure ulcers. The review showed staff were required to provide extensive assistance with bed mobility and transfers. The following issues were identified: a. Observation on 12/2/15 at 2:25 PM showed RN #1 performed pressure ulcer care for resident #20 in his/her bed. The observation showed the resident had a hardened area on his/her left heel that measured 4.0 cm by 3.5 cm. The resident's heels were lifted off the bed by a pillow placed under his/her ankles and a sheet lifting device was applied to the foot of the bed. The RN applied a "Tegaderm" foam heel dressing to the area. Interview with the RN at that time revealed the wound had been there for "a couple weeks" and was previously fluid filled. b. Review of a nurse's note dated 10/26/15 at 4:39 AM showed a "new area" that included a 4 cm by 2 cm "blister" with 6 cm of "redness around the area". Review of nurse's notes from 10/31/15 through 12/1/15 showed no further measurements of the area were obtained. c. Review of the Braden assessments (pressure ulcer risk) on 6/19/15 and 9/17/15 showed the resident was at "mild risk" to develop a pressure ulcer.	F 314		

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F 314	Continued From page 16 d. Review of the resident's care plan for "pressure ulcer" last revised on 10/6/15 showed the area to the left heel was not included. Further, the care plan did not identify the treatment for the area or the use of the sheet lifting device. e. Interview with the DON on 12/2/15 at 11:50 AM revealed the facility used the hospital for wound care and there were no residents at the facility with wounds that she knew of. f. Interview with the DON and MDS Coordinator on 12/3/15 at 11 AM confirmed the resident had a pressure ulcer and revealed the interventions should have been on the care plan. 3. Interview with the DON on 12/3/15 at 12:35 PM verified the wound documentation was lacking.	F 314		
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, medical record review, policy and procedure review,and review of manufacturer's operating manual, the facility failed to ensure side rails were assessed for safety for 3 of 3 sample residents (#9, #20, #45) who used side rails, and failed to ensure safe transfer techniques for 2 of 2 sample resident (#20, #27) observed to transfer with staff	F 323	GHLS will ensure that the environment for our Elders remains as free of accident hazards as is possible; and each Elder receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: including #9, #20 and #45 1. All Elders will have a Side Rail Assessment in ECS completed by 12-28-2015 & quarterly thereafter, or during a significant change assessment. 2. MDS Coordinator will add gait belt use to Care Plan of Elder #27. 3. MDS Coordinator will add the assistive device to the Care Plan of Elder #27. Continued Next Page Elder #20 will be transferred with 1 staff and assist of 2 staff.	

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F 323	Continued From page 17 assistance. The findings were: 1. Review of the 9/14/15 quarterly assessment showed resident #9 was cognitively intact and had diagnoses that included heart failure and chronic obstructive pulmonary disorder. Observation on 12/1/15 at 9:17 AM showed the resident had side rails attached to both sides of the bed. Both side rails were elevated while the resident was in bed. Review of the medical record showed there was no evidence that the side rails were assessed for safety. Review of the resident's care plan revised on 10/6/15 showed the the side rails were not addressed for use or safety. 2. Review of the 9/21/15 quarterly assessment showed resident #20 was cognitively intact and had diagnoses that included manic depression and senile delusion. Observation on 12/2/15 at 3:13 PM showed the resident had side rails attached to both sides of the bed. The right side rail was lowered and the left side rail was elevated. Review of the medical record showed there was no evidence that the side rails were assessed for safety. Review of the resident's care plan revised on 10/6/15 showed the the side rails were not addressed for use or safety. 3. Review of the 9/23/15 quarterly assessment showed resident #45 was cognitively intact and had diagnoses that included muscle weakness and secondary Parkinsonism. Observation on 12/3/15 at 9:40 AM showed the resident had a side rail attached to the outside of the bed and the other side of the bed was against the wall. Review of the medical record showed there was no evidence that the side rail was assessed for safety. Review of the resident's care plan revised	F 323	Continued F-323: 4. SDC will provide education to all direct-care staff regarding use of Sit-To-Stand with two people at all times, and will provide copies of the GHLS lift policy "Safe Lifting and Movement of Elders" during monthly team meetings. This will be completed by 1-15-2016. 5. GHLS Guide and SDC and monitor lift practices on a weekly basis during house walk-throughs, and randomly throughout each month. Findings will be reported out to QA quarterly and monitored for negative trends.	

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F 323	Continued From page 18 on 10/6/15 showed the the side rail was not addressed for use or safety. 4. Interview with the DON on 12/3/15 at 10:30 AM revealed the facility does not assess side rails for safety and confirmed that the side rails can increase a resident's risk for injury. 5. Review of the facility policy "Proper Use of Side Rails" revised on 7/23/15 showed "Purpose to ensure the safe use of side rails as Elder mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a Elder's medical symptoms...3. An assessment will be made to determine the Elder's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the Elder's: a. bed mobility; and b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet. 4. The use of side rails will be addressed in the resident care plan...8. The risks and benefits of side rails will be considered for each Elder...10. The elder will be checked periodically for safety relative to side rail use...12. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used)...14. Facility staff, in conjunction with the Attending Physician, will assess and document the Elder's risk for injury due to neurological disorders and other medical conditions." 6. Review of the significant change MDS assessment dated 10/6/15 showed resident #27 was severely cognitively impaired and had diagnoses that included arthritis and osteoporosis. Further, the resident required the	F 323		

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F 323	Continued From page 19 extensive physical assistance of 2 or more persons with transfers. The following concerns were identified: a. Observation on 12/2/15 at 3:45 PM showed Shahbaz #3 and the MDS coordinator assisted the resident to stand. they placed their arms under the resident's arms and lifted the resident out of the recliner to a standing position. The resident was then pivoted and seated in a wheelchair. No gait belt or other assistive device was utilized. b. Review of the ADL care plan revised 10/19/15 showed the resident needed extensive assist of 1 to 2 people; however, devices necessary for transfer were not identified. 7. Review of the quarterly MDS assessment dated 9/21/15 showed resident #20 was cognitively intact and had diagnoses that included manic depression and senile delusion. Further, the resident required the extensive physical assistance of 2 or more persons with transfers. The following concerns were identified: a. Observation on 12/2/15 at 3:13 PM showed Shahbaz #3 entered the resident's room with a "stand-up" lift to assist the resident to transfer. The staff member applied the lift sling, raised the resident, and took the resident into the bathroom. When the resident was finished in the bathroom, the staff member again lifted the resident and provided care, took the resident out of the bathroom, and lowered the resident into a wheelchair. The use of the lift was completed with only one staff member present. b. Review of the ADL care plan revised on 10/6/15 showed the resident required extensive assist of 1 to 2 people; however devices necessary for transfer were not identified. c. Review of the "Invacare Owner's operating	F 323		

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F 323	Continued From page 20 and Maintenance Manual" for the mechanical lift provided by the facility on 12/3/15 at 11:45 AM showed on page 4, "Safety Summary...Invacare recommends that two (2) assistants be used for ALL lifting preparation, transferring from and transferring to procedures..." 8. Interview with the DON on 12/3/15 at 10:30 AM revealed residents should be transferred to according their ability, which should be identified on the care plan. 9. Review of the policy titled "Safe Lifting and Movements of Elders" revised 7/23/15 showed "...1. Elder safety, dignity, comfort and medical condition will be incorporated into goal and decisions regarding the safe lifting and moving of Elders. 2. Manual lifting of Elders shall be eliminated when feasible...4. Staff responsible for direct care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices."	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	GHLS will ensure sanitary conditions and safe food practices will be maintained by: Continued Next Page	

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F 371	Continued From page 21 Based on observation, staff interview, review of policy and procedure, and review of cleaning schedules, the facility failed to ensure sanitary conditions and safe food practices were maintained in 4 of 5 kitchens (Scott, Watt, Whitney, Founders). The findings were: 1. Interview with the dietary manager on 12/1/15 at 11 AM revealed the shell eggs being used in the facility were not pasteurized. The manager stated they were unable to purchase pasteurized shell eggs from their food provider. The manager stated eggs being prepared for the residents were to be cooked with no runny yolks. She stated the temperature should be taken for every egg cooked and the expectation was to cook to a temperature of 165 degrees F. Review of the Food Preparation and Service policy revised December 2010 showed "11. Under no circumstances may uncooked or undercooked eggs be served. Unpasteurized eggs will not be prepared or served to the residents." Observation in the Whitney Cottage on 12/1/15 at 9:17 AM showed resident #9 was in bed eating breakfast. The breakfast consisted of 2 eggs with runny yolks and toast. One egg was intact and the yolk moved when the resident cut the other egg. There was no evidence the egg had been checked for temperature because the membrane of the egg was not punctured. Liquid yolk was smeared on the resident's plate. Interview with Shahbiz #1 on 12/1/15 at 11:50 AM revealed the staff did not check the temperature of "over easy eggs" because it would cause the yolk to run. In addition, the aide revealed there were 2 residents in the house who requested "poached" eggs and resident #9 who requested "over easy" eggs daily. 2. Observation on 11/30/15 at 3:40 PM in the	F 371	Continued F-371: 1. Pasteurized eggs have been ordered for all elders through an approved supplier; Sysco. In the future, all shell eggs that are ordered will be Pasteurized. Pasteurized shell eggs that are prepared for residents with runny yolks are to be cooked to the appropriate temperature of 145 degree F. Temperatures for each egg cooked will be logged in a Temperature log book located in each cottages kitchen. Monitoring will be done Monday through Friday by Dietary mentor for 30 days to ensure shell eggs are being cooked and served under sanitary conditions. After 30 days of successful monitoring, Dietary Mentor will monitor every week to assure that shell eggs are appropriately cooked. Any deviations from safe food practices will be corrected through training and results will be reported to the QA Committee. 2. GHLS food shall be protected from cross contamination by separating raw meat during transportation from storage to each cottage. GHLS has ordered individual transporting bags for each cottage to separate raw meats from ready to eat foods. Dietary mentor will be present to monitor food transportation from storage to each cottage kitchen. Any deviations from safe food transport will be monitored by Dietary Mentor and results reported to the QA Committee. Completed 12/23/15. Continued Next Page	12/29/2015

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	535054	A. BUILDING _____ B. WING _____	12/03/2015

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

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F 371	Continued From page 22 Founders Cottage showed food coordinator #1 was putting away groceries. The method used to transport the food items from the main kitchen to the cottage kitchens was a wagon. The food in the wagon included 3 large rolls of raw ground beef, 1 raw pork loin roast, and other packaged foods such as margarine and produce. The raw meat was not separated from the other food in the wagon. Interview with the food coordinator at that time verified the raw meat should be separated from the other food items. According to Food Code 2013, U.S. Public Health Service: 3-302.11 "(A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, and (b) Cooked READY-TO-EAT FOOD... " 3. The following equipment was identified as needing cleaned or replaced: a. Observation on 12/2/15 at 11:05 AM showed the plastic drinking glasses in the Scott Cottage were in poor condition. The glasses were damaged with cracks and chips. There were 10 large drinking glasses and 5 smaller glasses counted which were available for use. Interview with Shahbaz #5 revealed they had recently gotten some new glasses and needed to get more. b. Observation on 12/2/15 at 11:55 AM in the Watt Cottage showed a cutting board and 8 plastic drinking glasses were in poor condition.	F 371	Continued F-371: 3. GHLS equipment food-contact surfaces and utensils shall be clean to sight and touch. Equipment and utensils will be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions. GHLS will order new melamine drinking glasses for every Cottage that meets the F371 requirements by 12/30/15. GHLS will replace cutting boards in every cottage on 12/29/15. Drinking glasses will be ordered by 12/30/15. Monitoring will be done by the Dietary Mentor using a monthly checklist to ensure equipment is appropriate for food service use. Monitoring results will be reported to the QA Committee. 4. GHLS non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. Kitchen cleaning schedules were checked and visually monitored for cleanliness on 12/14/15. Dietary Mentor will visually monitor weekly to assure that kitchen equipment is being cleaned in accordance to the existing cleaning schedule. Results will be reported to QA Committee.	12/30/2015 12/14/2015

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F 371	Continued From page 23 The cutting board was scored and had areas of discoloration. The drinking glasses were chipped and cracked and were in use for the residents during the meal. c. Observation on 12/2/15 at 12 PM in the Founders Cottage showed 11 plastic drinking glasses that had chips and cracks. These glasses were in use by the residents dining at that time. d. Observation on 12/2/15 at 12:10 PM in the Whitney Cottage showed 3 drinking glasses being used by residents that were chipped and cracked. In addition, the hood vents located above the cooking range were soiled with a build-up of grease and dust. Review of the cleaning list showed these vents were to be cleaned every Friday morning, and they were marked as having been cleaned on 11/27/15. e. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." f. According to Food Code 2013, U.S. Public Health Service: 4-201.11 "EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions.	F 371		
F 441 SS=D	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.	F 441	GHLS will ensure that infection prevention practices are followed during personal cares for all Elders. This will be accomplished by: Continued Next Page	01/15/2016

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F 441	Continued From page 24 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections 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, and policy and procedure review, the facility failed to ensure infection prevention practices were followed for 1 of 5 sample residents (#9) during observed personal care. The findings were:	F 441	Continued F-441: 1. Infection Preventionist and SDC will in-service all direct care staff on proper handling of soiled laundry at their monthly team meetings. They will also discuss expected use of PPE when there is a risk of splashing or splattering of blood or body fluids, and the proper handling of a catheter drainage bag when moving an Elder. This will be completed by 1-15-2016. 2. Disposable plastic aprons will be available next to all hoppers in the laundry room. 3. Gallon zip-lock bags will be kept in the bathrooms of those Elders with colostomies to transport colostomy bags to the laundry room. 4. DON/Infection Preventionist will observe direct-care staff perform colostomy care weekly to ensure infection prevention practices are being followed. Results of these observations will be reported to the QA Committee quarterly and any negative trends will be addressed and a plan of action initiated, if necessary.	

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F 441	Continued From page 25 1. Observation of care for resident #9 on 12/1/15 at 1:36 PM showed Shahbaz #1 and Shahbaz #2 entered the resident's room to assist with ADL care. Shahbaz #1 lifted the resident's catheter drainage bag off the right side of the bed as the resident was laying in bed. While moving the drainage bag, the staff member held it above the resident's bladder. Urine was visible in the tubing and flowed backward toward the resident's bladder. The staff member then set the drainage bag on the bed sheets where it leaked onto the sheets. Both staff members then washed their hands and applied gloves. The drainage bag was removed and a leg bag was applied. Shahbaz #1 obtained a plastic bag and placed it on the resident's lap and removed the resident's colostomy bag. The staff member left the plastic bag on the residents legs and exited the room while holding the colostomy bag. The colostomy bag was taken to the laundry room and was not contained during transport. The staff member washed out the colostomy bag in the facility's hopper. No personal protective equipment, except the gloves, was utilized. Shahbaz #2 exited the resident's room with the soiled linen from the resident's bed, and entered the laundry room. When entering the laundry room Shahbaz #2 used a contaminated gloved hand to open the door. The linen was not contained during transport. The staff member returned to the resident's room and Shahbaz #1 re-applied the colostomy bag. 2. Interview with the DON on 12/3/15 at 10:30 AM revealed the staff members should have performed hand hygiene before contact with the resident and the drainage bag should have been kept below the bladder to prevent backflow of urine because of risk for infection. Further, the	F 441		

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F 441	Continued From page 26 colostomy bag and linen should have been contained during transport and more personal protective equipment should have been worn while using the hopper. 3. Review of policy titled "Handwashing/Hand Hygiene" revised on 7/23/15 showed "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-microbial soap and water under the following conditions:...h. Before and after assisting an Elder with personal care (e.g., oral care, bathing): i. Before and after handling peripheral vascular catheters and other invasive devices;...r. After handling soiled or used linens, dressings, bedpans, catheters and urinals;..." 4. According to Walters and Kluwar, Lippincott's Nursing Procedures, 7th Edition, 2015, page 713-714 stated, "Standard Precautions...If the task or procedure may result in splashing or splattering of blood or body fluids to the face, a mask and goggles or face shield should be worn. If the task or procedure being performed may result in splashing or splattering of blood or body fluids to the body, a fluid resistant gown or apron should be worn..." Further review showed, "Implementation...Place all items that have come in direct contact with the patient's secretions, excretions, blood, drainage, or body fluids-such as nondisposable utensils or instruments-in a single impervious bag or container labeled biohazardous before removal from the room. Place linens and trash in single bags of sufficient thickness to contain the contents..."	F 441		