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Healthcare Licensing and Surveys

PRINTED: 12/15/2016  
FORM APPROVED

## Healthcare Licensing and Surveys

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>WY0042</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X3) DATE SURVEY COMPLETED<br><br><b>12/01/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE<br/>SHERIDAN, WY 82801</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |
| (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) COMPLETE DATE                                  |
| S 000                                                                      | <b>OPENING COMMENTS</b><br><br>Rules and Regulations utilized for this survey are:<br><br>Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000<br><br>Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | S 000                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |
| S2924                                                                      | <b>Ch 11 Sec 6 (a)(iv) Physical Environment</b><br><br>(a) The building(s) of the Nursing Care Facility shall be constructed, arranged and maintained to ensure the health and welfare of all residents.<br><br>(iv) Shower/bath and resident lavatories shall be set to provide water of a temperature not to exceed 110 degrees Fahrenheit.<br><br>This State Rule and Regulation is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure hot water temperatures in resident bathrooms and common areas did not exceed 110 degrees Fahrenheit (F) in 4 of 4 buildings (Scott, Whitney, Founders, Watt). The findings were:<br><br>1. Observation in the Scott building on 11/30/16 between 3:32 PM and 3:44 PM showed the following:<br>a. The hot water temperature at the resident shower in room #5 measured 116.1 degrees F.<br>b. The hot water temperature at the kitchen sink accessible to residents measured 112.5 degrees F.<br>c. The hot water temperature at the resident's shower in room #12 measured 128.1 degrees F. | S2924                                                                                    | Greenhouse Living for Sheridan will ensure that the water at all fixtures accessible by residents maintain a temperature of no more than 110 degrees Fahrenheit (F) in all 4 of 4 cottages by:<br>1. Adjusting the water heaters to a maximum limit of 110 degrees (F) in all 4 cottages. These adjustments were completed 12/19/2016.<br>2. Adding the task of monitoring the water temperatures on all fixtures accessible to residents to the preventative maintenance schedule and recorded monthly. Temperatures will be taken using a calibrated, instant-read thermometer.<br><br>3. Monitoring of the water temperatures in resident rooms will be added to the Quality Assurance Performance Indicators (QAPI) for three months to track any possible trends in rising water temperatures. The results will be reported at the monthly Safety Committee Meeting and to the QAPI Committee quarterly.<br>4. If water temperatures continue to remain out of compliance, then it will be taken to the Safety Committee to focus on a solution. The Safety Committee will report the results to the QAPI Committee.<br>Responsible employee: Maintenance Director. | 1/13/2017                                           |

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Martha Newman R.N., DON*

1-10-2017

STATE FORM

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SSN011

If continuation sheet 1 of 2

1/10/17 - This POC accepted with agreed to changes between Chris Szymanski, Administrator, Martha Newman, DON, and Terry Madden, Health Surveyor.

1/10/17

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>WY0042              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>12/01/2016 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801 |                                                                                                                          |                          |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                 |
| S2924                                                               | <p>Continued From page 1</p> <p>2. Observation in the Whitney building on 11/30/16 between 3:45 PM and 4:07 PM showed the following:</p> <ul style="list-style-type: none"> <li>a. The hot water temperature at the resident shower in room #1 measured 122.7 degrees F.</li> <li>b. The hot water temperature at the resident shower in room #9 measured 134.6 degrees F.</li> <li>c. The hot water temperature at the tubroom tub faucet measured 115 degrees F.</li> </ul> <p>3. Observation in the Founders building on 11/30/16 between 4:08 PM and 4:32 PM showed the following:</p> <ul style="list-style-type: none"> <li>a. The hot water temperature at the resident shower in room #4 measured 134 degrees F.</li> <li>b. The hot water temperature at the resident shower in room #8 measured 138.5 degrees F.</li> <li>c. The hot water temperature at the resident sink in room #8 measured 114.6 degrees F.</li> </ul> <p>4. Observation in the Watt building on 11/30/16 between 4:33 PM and 4:52 PM showed the following:</p> <ul style="list-style-type: none"> <li>a. The hot water temperature at the resident shower in room #2 measured 124.3 degrees F.</li> <li>b. The hot water temperature at the resident shower in room #10 measured 131.3 degrees F.</li> <li>c. The hot water temperature at the tubroom tub faucet measured 118 degrees F.</li> </ul> <p>5. Tour with maintenance staff member #1 on 11/30/16 at 5:51 PM verified that water temperatures were above 110 degrees F. He stated that showers were not part of the water temperature logs that were kept. Further, staff were aware the resident showers did not have mixing valves to regulate water temperatures.</p> | S2924                                                                            |                                                                                                                          |                          |                                                 |

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STATE FORM

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SSN011

If continuation sheet 2 of 2

Martha Newman R.N., DON 1-10-2017

1/10/17