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

PRINTED: 12/15/2016
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 ______	C 12/01/2016

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 and licensure survey was conducted on 11/28/16 in addition with complaint intake WY00002277. It was determined, bases upon the findings of the survey team, that the complaint was substantiated. The following common abbreviations are used throughout this document: DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set RN Registered Nurse Shahbaz Certified Nurse Aide Shahbazim Certified Nurse Aides Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Social Worker will meet with the Administrator to review the facility policies and practices to ensure that protocols for conducting thorough investigations and for preventing further potential abuse while investigations are in progress are current. The protocols describe the types and locations of investigation data to be documented. 2. The Administrator will ensure that performing a physical assessment for alleged physical or sexual abuse will be added to the facility policy and that the policy is consistent with the requirements stated in the regulations. 3. The Social Worker interviewed elder #167 on 3/14/16 and #174 on 7/24/16 to assure they felt safe and comfortable.	1/13/2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Szymanski
TITLE: Administrator
(X6) DATE: 1/9/17 revised

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.

RECEIVED
JAN 09 2017
Healthcare Licensing and Surveys

This POC accepted 1/10/17 by phone Chris Szymanski [illegible] Megan Madden, Health Surveyor 1/10/17

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F 225	Continued From page 1 body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the	F 225	Continued From page 1 As part of the quarterly MDS review, individual #167 will be asked if she feels safe and comfortable. Elder #174 expired on 12/24/16. 4. In the event allegations of physical or sexual abuse are made known or identified, the Director of Nursing and Social Worker will work together to ensure these residents are provided the medical treatment, emotional support and reassurance necessary to meet their individual needs. The residents will be assessed and a plan of care will be developed when an allegation of this nature is made. The residents will be monitored for changes, reassessed and the plan of care revised as necessary. A physical examination will be conducted when necessary to assess the physical and medical status of the resident. Additional assessments will be conducted as necessary to meet the needs of the residents and as necessary to fully investigate allegations of physical or sexual abuse. The information obtained will be documented. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. The Social Worker will make rounds with residents to identify and document concerns quarterly. Staff responsible for monitoring resident concerns will notify the Director of Nursing and/or the designated administrative contact person on-call as necessary to assure all required actions are completed and when required, documented. 2. The Social Worker will be available to attend Resident Council and/or meet with individual residents or their representatives upon request	

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F 225	Continued From page 2 administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 staff interview and review of facility abuse investigations, the facility failed to adequately investigate allegations of abuse for 2 of 3 abuse investigations reviewed (involving resident #167 and #174). The findings were: 1. Review of the abuse investigation dated 3/4/16 showed an allegation of physical abuse was brought to the attention of the facility by a family member of resident #167. The allegation was related to bruising on the resident's wrist. The facility's investigation failed to include a physical assessment of the resident, including the bruising to the wrist. This information was, however, mentioned in a late entry dated 3/7/16. 2. Review of the abuse investigation dated 7/24/16 showed an allegation of sexual abuse was made by resident #174 against 2 shahbazim. The facility's investigation failed to include a physical assessment of the resident. 3. Interview with the social services director on 12/1/16 at 9:15 AM revealed investigations into allegations of abuse included obtaining written statements from any residents, staff, or family members involved. She also stated she looked at CNA charting as part of the investigation, but did not always include nursing assessments. She confirmed nursing assessments should have been included as part of the investigations.	F 225	Continued From page 2 to provide information and support about facility policy about physical or sexual abuse. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Director of Nursing Services conducted training with the nurses on when to perform a physical assessment and where to document it when there is an investigation of alleged physical or sexual abuse. 2. The Social Worker will develop a tool to be used during an investigation of alleged physical or sexual abuse which will include ensuring a physical assessment has been completed and charted. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. This plan will be implemented and the corrective action evaluated for its effectiveness. 2. The plan of correction will be integrated into the Quality Assurance Performance Improvement (QAPI) program. 3. The Social Worker will report to the Quality Assurance Manager any incident of alleged physical or sexual abuse that required a physical assessment. The Quality Assurance Manager shall review implementation of the facility policy and practices regarding resident abuse on a quarterly basis to ensure compliance. Responsible: Social Worker.	

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F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the dignity of 1 of 11 sample residents (#11). The findings were: Observation on 11/28/16 at 4:25 PM showed resident #11 sitting in a wheelchair next to the dining room table with 7 other residents present. Shahbazim #1 and #2 approached the resident to transfer him/her to a dining room chair. As they were assisting the resident to stand, shahbaz #1 pulled the back of the resident's pants and brief open to look inside the brief, in full view of the other residents in the area. The shahbazim then wheeled the resident to his/her bathroom. Interview at 4:40 PM, after the resident's brief was changed, with shahbaz #2 confirmed the resident's brief had been soiled. Interview with the DON on 12/1/16 at 11 AM confirmed the shahbazim should not have checked the resident's brief in a public area.	F 241	Green House Living for Sheridan will ensure that the dignity, individuality, and privacy of every Elder is protected and respected. This will be accomplished by; 1. The guide will provide training to staff member engaged in deficient practice and continue to monitor this staff member randomly for deficiencies in practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. The Guide will make daily rounds among the residents. The Social Worker will train all Shahbazim on resident's rights at their monthly team meetings. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practices do not recur: 1. The Guide will train the facility staff in resident rights, especially the right to have personal privacy, every year. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. The Quality Assurance Committee shall review the Guide's report for protecting resident rights to privacy based on observations during daily rounds on a quarterly basis	1/13/2017
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by:	F 253	Greenhouse Living for Sheridan will ensure that a sanitary and well-maintained environment is provided in all 4 of 4 cottages by: 1. Repairing the scrape at the exit door near room #4 of the Whitney cottage to restore it to a safe, cleanable state without exposed wood or rough surfaces.	1/13/2017

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F 253	Continued From page 4 Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 3 of 4 resident cottages (Whitney, Founders, Watt). The findings were: 1. Observation in the Whitney cottage on 11/30/16 between 3:45 PM and 4:07 PM showed the following: a. The exit door by room #4 had a 7-inch long scrape on the wood creating a rough surface. b. The wall corner by the kitchen entrance closest to the dining room table had a scrape 3 inches long at 20 inches above the baseboard which exposed bare metal. 2. Observation in the Founders cottage on 11/30/16 between 4:08 PM and 4:32 PM showed the following: a. The entrance of the building had a line of scraped-off paint measuring 19 inches at a height of 30 inches above the baseboard, which exposed underlying drywall. b. The wall behind the bed in room #4 had a line of scraped-off paint measuring 20 inches vertically starting at a height of 8 inches above the baseboard, which exposed underlying drywall. c. The shelf by the hairdresser station sink was not secured to the wall, creating a possible hazard. d. A wall in room #8 had a line of scraped-off paint measuring 20 inches at a height of 31 inches above the baseboard, which exposed underlying drywall. 3. Observation in the Watt cottage on 11/30/16 between 4:33 PM and 4:52 PM showed the following: a. The carpet next to the dining room floor	F 253	Continued From page 4 2. Repairing the drywall and paint scrapes near the kitchen entrance of the Whitney cottage to restore the walls to a safe, cleanable state. 3. Repairing the drywall and wall paint scrape in the entrance and rooms #4 and #8 of the Founders cottage to restore the walls to a safe, cleanable state. 4. Securing the shelf near the hairdresser station in the Founders cottage to the wall using heavy-duty fasteners. 5. Repairing the carpet seam in the Watt cottage near the dining room floor with carpet adhesive to return the carpet to a safe, cleanable condition. 6. Replacing the carpet throughout the common areas of the Watt cottage. The carpet replacement will include all areas that were noted to be stained in Observation #3. The carpet replacement is scheduled for 1/9/2017 by an outside contractor. The new carpet will be of a modular construction to allow easy replacement of stained areas in the future. 7. Corner protectors will be installed on the wall corners near the kitchen entrances in all 4 cottages to prevent damage in the future and cover the exposed bare metal. 8. Adding the task of inspecting and recording the condition of the doors, walls, paint, and drywall throughout all 4 cottages to the monthly facility inspection checklist. Visual inspections and records will be completed monthly by the GHLS maintenance department. If future damages are discovered, they will be documented and repaired by the GHLS maintenance department. 9. Adding the task of inspecting the security of fixtures and furniture throughout all 4 cottages to the quarterly facility inspection checklist. Physical inspections and records will be completed quarterly by the GHLS maintenance department.	

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F 253	Continued From page 5 had a separated seam measuring 2.5 inches. b. The carpet in front of the patio window had a dark stain that measured 18 inches by 14 inches. c. The carpet in front of the kitchen entry near the hand wash station had a dark stain which measured 50 inches across. d. The carpet in front of the closet across from room #10 had a dark stain measuring 40 inches by 55 inches. e. The carpet in front of the nurse's room entrance had a dark stain measuring 40 inches by 55 inches. Interview on 12/1/16 at 10:03 AM with the maintenance supervisor revealed the facility had identified some of the areas; however, there was no timeline for correction. Further, it was confirmed that the areas were visibly dirty and required maintenance.	F 253	Continued From page 5 If future hazards or potential hazards are discovered, they will be documented and repaired by the GHLS maintenance department. 10. Adding the inspection results from items #8 and #9 to the Quality Assurance Performance Indicators (QAPI) for three months and six months, respectively, to track the response time by the maintenance department for possible repairs and corrections, if any are found. The results will be reported at the monthly Safety Committee Meeting and to the QAPI Committee quarterly. 11. If inspection results reveal that the reported damages and or hazards remain out of compliance within the monthly and quarterly time frames, 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.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. Resident #187 was weighed after being released from bed rest. The MDS was updated to reflect their new weight. 2. The Director of Nursing and the MDS Coordinator will meet with the Administrator to review the facility protocols regarding resident assessment including policies and practices to ensure that assessments accurately reflect the status of the residents. 3. The Director of Nursing and the MDS Coordinator will meet to review the needs of individuals affected by the deficient practice. The MDS Coordinator will ensure that assessments accurately reflect the status of the residents. How the facility will identify other residents having the potential to be affected by the same deficient practice:	1/13/2017

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F 278	Continued From page 6 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, Resident Assessment Instrument (RAI) User's Manual review, and staff interview, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 11 sample residents (#187). The findings were: 1. Review of the medical record showed resident #187 had diagnoses that included pressure ulcer to left buttock stage 4, unspecified protein-calorie malnutrition and quadriplegia. Review of the resident's care plan showed the resident was to be weighed monthly. The following concerns were noted: a. Review of the 5/4/16 admission MDS assessment for resident #187 showed the resident weight was recorded as 189 pounds (lb.). Further, review of the 7/22/16 and 10/17/16	F 278	Continued From page 6 1. The MDS Coordinator will ensure steps have been taken to obtain required assessment data in a coordinated, timely and accurate manner. The Director of Nursing will be informed of any delays in obtaining accurate data and completing the assessment in a timely manner. 2. The MDS Coordinator will obtain a record audit monthly from the Quality Assurance Manager of resident assessments to ensure that they accurately reflect the status of the residents. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Quality Assurance Manager will ensure that copies of the clinical records and/or other documents containing resident-related information are audited monthly to ensure data are accurate. The audit results will be provided to the MDS Coordinator for further action. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. The Quality Assurance Manager will perform monthly random audits of resident assessments to ensure accuracy. 2. This plan will be implemented and the corrective action evaluated for its effectiveness. 3. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. 4. The accuracy of assessment data will be reviewed on a quarterly basis by the Quality Assurance Performance Improvement committee to ensure compliance. Responsible: MDS Coordinator.	

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F 278	Continued From page 7 quarterly MDS assessments also showed the resident weight was recorded as 189 lb. b. Review of the resident's weight record showed s/he had been weighed upon admission with no further weights done. Further, review of weight documentation showed a note dated 9/5/16 that indicated "do not weigh per [the DON]." c. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.14, October 2016, Section K0200 B, showed the weight recorded was to be based on the most recent measure in the last thirty days. It further instructed if the last recorded weight was taken more than 30 days prior to the assessment reference date (ARD) of the assessment, or the previous weight is not available, to weigh the resident again. Further, review of section 3.3, "coding conventions", showed a dash (-) value would be used to indicate that an item was not assessed. d. Interview on 12/1/16 at 10:00 AM with the MDS coordinator revealed she was aware the resident's weight had not been assessed since 5/4/16, and the weights recorded on the quarterly MDS assessments dated 7/22/16 and 10/17/16 were not verified as the accurate weight of the resident within the 30 day time frame.	F 278		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323	Regarding Observations #1 - #5: 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: 1. Adjusting the water heaters to a maximum limit of 110 degrees (F) in all 4 cottages. These adjustments were completed 12/19/2016.	1/13/2017

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F 323	Continued From page 8 and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility water temperature logs, the facility failed to ensure safe water temperatures in resident showers in 4 of 4 resident cottages (Founders, Scott, Watt, Whitney). Also, the facility failed to ensure carpets were secured to prevent falls in 4 of 4 resident cottages (Founder, Scott, Watt, Whitney). The findings were: Regarding water temperatures in resident areas: 1. Observation in the Scott building on 11/30/16 between 3:32 PM and 3:44 PM showed the hot water temperature at the resident shower in room #12 measured 128.1 degrees Fahrenheit (F). 2. Observation in the Whitney building on 11/30/16 between 3:45 PM and 4:07 PM showed the hot water temperature at the resident shower	F 323	Continued From page 8 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. 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. 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. Regarding Observations #6 - #12: Greenhouse Living for Sheridan will ensure that the rugs in all 4 cottages are secured and of a better composition to prevent falls by: 1. Purchasing and installing rugs that are heavier and contain a non-slip backing to prevent the rugs from rolling, curling, or sliding when in use. 2. Educating the Shahbazim regarding the proper placement of rugs to prevent falls and door obstruction. This training will be incorporated into the written housekeeping guides and the monthly housekeeping coordinator meetings. 3. Visually monitoring the integrity and effectiveness of the new rugs in preventing falls will be added to the Quality Assurance Performance Indicators (QAPI) for three months to determine if the new rugs are a permanent solution. The results will be reported at the monthly Safety Committee	

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F 323	Continued From page 9 in room #1 measured 122.7 degrees F., and the hot water temperature at the resident shower in room #9 measured 134.6 degrees F. 3. Observation in the Founders building on 11/30/16 between 4:08 PM and 4:32 PM showed the hot water temperature at the resident shower in room #4 measured 134 degrees F., and the hot water temperature at the resident shower in room #8 measured 138.5 degrees F. 4. Observation in the Watt building on 11/30/16 between 4:33 PM and 4:52 PM showed the hot water temperature at the resident shower in room #2 measured 124.3 degrees F., and the hot water temperature at the resident shower in room #10 measured 131.3 degrees F. 5. Tour with maintenance staff member #1 on 11/30/16 at 5:51 PM verified that water temperatures were above 120 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. Regarding the carpeting in resident cottages: 6. Observation on 11/28/16 at 4:25 PM in the Scott building showed the floor mat at the key-coded entrance door was found to be easily kicked up and moved. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 7. Observation on 12/1/16 at 8:11 AM in the Whitney building showed the floor mat at the key-coded entrance door was found to be easily kicked up and moved. There was no tape or	F 323	Continued From page 9 meetings and to the QAPI Committee quarterly. 4. Based on the criteria in Item #1, If the new rugs are determined to be inadequate for preventing falls, 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. Responsible employee: Maintenance Director.	

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F 323	Continued From page 10 adhesive to the rubber underside of the mat to ensure safety. 8. Observation on 12/1/16 at 8:13 AM in the Whitney building showed the floor mat at the main entrance door was lifted up onto the door threshold, and did not lie flat. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 9. Observation on 12/1/16 at 8:15 AM in the Founders building showed the floor mat at the key-coded entrance door had three bubbled edges which did not lie flat. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 10. Observation on 12/1/16 at 8:17 AM in the Founders building showed the floor mat at the main entrance door was lifted up onto the door threshold, and did not lie flat. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 11. Observation on 12/1/16 at 8:21 AM in the Watt building showed the floor mat at the key-coded entrance door had two bubbled edges which did not lie flat. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 12. Observation on 12/1/16 at 8:17 AM in the Founders building showed the floor mat at the main entrance door was lifted up onto the door threshold, and did not lie flat. There was no tape or adhesive to the rubber underside of the mat to ensure safety. 13. Interview on 12/1/16 at 9:42 AM with the	F 323		

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F 323	Continued From page 11 maintenance supervisor revealed the mats were provided by an outside company and were brought to the facility. He observed and confirmed the mats were easy to move out of place and were not lying flat on the floor, which created a safety hazard.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441	Green House Living for Sheridan will ensure that all tubing for oxygen equipment and accessories will be changed monthly. This will be accomplished by: 1. Elder #187 had the tubing changed on her SVN on 12-1-2016 NOC shift and was scheduled for monthly change-out of tubing on the first Thursday of every month henceforth. Elder was discharged to home on 12-20-2016. 2. All nursing personnel were in-serviced on oxygen tubing changes at the monthly nurses' meeting on December 15, 2016. 3. All Elders at GHLS with orders for oxygen or nebulizer treatments have monthly tubing changes scheduled on their TAR (12-22-2016). 4. Guide will monitor oxygen tubing dates as part of her weekly walk-throughs in every cottage. 5. DON/Infection Preventionist will monitor TARs weekly for evidence of completion of tubing changes. Results of these observations and walk-throughs will be reported to the QA Committee quarterly and any negative trends will be addressed and a Plan of Action initiated.	1/13/2017

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F 441	Continued From page 12 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to follow an infection prevention and control program for one random observation of small	F 441		

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F 441	Continued From page 13 volume nebulizer use (involving resident #187). The findings were: 1. Observation on 11/29/16 at 8:12 AM showed resident #187 had a small volume nebulizer machine at his/her bedside table. The machine had tubing connected to a nebulizer cup and mouthpiece. The tubing was dated "10/26". The tubing was further observed on 11/30/16 and 12/1/16 and showed the same date. 2. Review of the facility policy entitled, "Respiratory Equipment Change-Out," last revised 6/8/16 showed small volume nebulizers and tubing were to be dated and changed out monthly. 3. Interview on 12/1/16 at 8:40 AM with RN #1 revealed that oxygen and nebulizer tubing was changed monthly by the night nurse. She further confirmed the date 10/26/16 as the date the tubing had last been changed.	F 441		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (I) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514	Green House Living for Sheridan will ensure that every Elder has a complete medical record, including the times when the EMR is unavailable. This will be accomplished by: 1. Each cottage at GHLS will maintain in the nursing office a notebook with blank MARs, TARs, and Progress Notes corresponding to the twelve rooms in each cottage. MARs and TARs will be filled in by nursing, using the most recent paper copy of Physician Orders kept in each Elder's physical chart. 2. The Shahbazim will have a notebook at their desk in each kitchen which contains blank Daily Cares charting sheets for each of their twelve Elders. This will include an area	1/13/2017

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F 514	Continued From page 14 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the medical record was complete for 36 of 48 residents (#11, #17, #49, #50, #51, #52, #53, #54, #78, #87, #88, #89, #93, #94, #95, #105, #115, #117, #119, #132, #133, #139, #144, #160, #162, #164, #175, #177, #178, #180, #182, #183, #184, #186, #188, #190). The findings were: Interview with the Director of Human Resources on 11/30/16 at 10:50 AM revealed the facility had an issue with their electronic medical record system from 8/12/16 until 8/15/16. He stated the facility staff charted on physical forms during that timeframe because the server was down. Review of the resident list during those dates provided by the DON showed the census was 48. The	F 514	Continued From page 14 for documenting q15 minute rounds. 3. Upon restoration of service to the EMR, all paper charting will be filed in the physical chart of each Elder, which is kept in the nursing office of each cottage. 4. QA Committee will review Plan of Action quarterly. In the event of a loss of the EMR, DON and QA Coordinator will monitor charting daily until EMR service resumes. Negative trends will be brought to the QA Committee to revise Plan of Action.	

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F 514	Continued From page 15 following concerns were identified: a. Review of written documentation provided by the DON for the 8/12/16 through 8/15/16 timeframe showed 12 residents had MARs. The review showed the following residents did not have MARs: #11, #17, #49, #50, #51, #52, #53, #54, #78, #87, #88, #89, #93, #94, #95, #105, #115, #117, #119, #132, #133, #139, #144, #160, #162, #164, #175, #177, #178, #180, #182, #183, #184, #186, #188, #190. b. Interview with the DON on 12/1/16 at 11:45 AM confirmed that all 48 residents at the facility from 8/12/16 through 8/15/16 had medication orders. She further confirmed the facility had no additional documentation of resident medication administration for that period.	F 514		
F 517 SS=E	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, emergency policy and procedures review, and Call History review, the facility failed to ensure an adequate plan was developed to address call-light system failure concerning 1 event of call-light system failure for 4 of 4 cottages (Founders, Scott, Watt, Whitney). The findings were: Interview with the maintenance director on 12/1/16 at 8:40 AM revealed the electronic call-light system for all four resident cottages, (Founders, Scott, Watt, Whitney) failed to operate from 8/12/16 at 6:38 AM until 8/29/16 at 11:52 AM	F 517	Greenhouse Living for Sheridan will meet the requirement of being prepared for all potential emergencies and disasters in all 4 of 4 cottages by: 1. Developing and writing detailed plans and procedures that address Information Technology (IT) systems failures specific to the equipment and software owned and operated by GHLS, including: GHLS Network Server, Nurse Charting, Nurse-Call (call light) System, Telephone Service, Internet Service, and GHLS Email Server. 2. Integrating the IT Failure plans and procedures into the GHLS Disaster and Emergency Preparedness documentation, training, and periodic drills for all GHLS employees. 3. Conducting employee trainings and drills will be added to the Quality Assurance Performance Indicators (QAPI) for three months to ensure that all employees have received and understand the IT Failure plans and procedures. The results will be reported at	1/13/2017

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F 517	Continued From page 16 due to a server issue. He stated that since the call-light failure the facility had received 48 manual bells that could be rung by residents if the call-light system fails in the future. Review of the Call History for the call-light system confirmed the call light system was not operating for resident rooms during that timeframe. The following concerns were identified: a. Review of the facility emergency policy and procedures revealed that call-light system failure was not addressed. b. Interview with shahbaz #3 in the Founders Cottage on 11/30/16 at 12 Noon, and shahbaz #4 in the Founders Cottage on 11/30/16 at 12:15 PM, revealed that during the call-light outage of 8/12/16-8/29/16 the staff checked on the most vulnerable residents every 15 minutes. They further stated the residents with personal phones had the facility phone number added to use for speed dial to communicate with staff, and the facility did not have a set time to check on those residents. They stated the facility did not have physical bells for residents to ring for help during the outage, and there was no coordinated staff training to address the call-light issue. Shahbaz #4 further stated that staff used the daily nurse report charting to document any issues. c. Interview with shahbaz #5 in the Watt Cottage on 11/30/16 at 11:16 AM revealed that during the call-light outage of 8/12/16-8/29/16 the staff checked on the most vulnerable residents every 15 minutes, and other residents every 30 minutes to every hour. d. Interview with the DON and MDS coordinator on 11/30/16 at 3:30 PM confirmed the facility did not have a specific and documented plan during the 8/12/16-8/29/16 call-light outage to address that emergency, and the potential for that emergency to happen again. However, each	F 517	Continued From page 16 the monthly Safety Committee meetings and to the first quarterly QAPI Committee meeting. 4. If it is determined that staff members remain untrained, or that the plans and policies inadequately prepare staff members for an IT failure, then it will be taken to the Safety Committee for review and improvement. The Safety Committee will report the results to the QAPI Committee. Responsible employee: Maintenance Director.	

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F 517	Continued From page 17 stated that an emergency plan to address a potential call-light outage was being formulated by the Safety Committee. Each confirmed the facility did not document the checks on residents during the call-light outage, and they continued to instruct staff to document by exception (when an occurrence warrants).	F 517		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 520	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Quality Assurance Manager will meet with the Administrator to review the regulations and facility policies regarding the management of the facility. The policy will describe the purpose and membership of the quality assessment and assurance committee. The committee will develop and implement appropriate plans of action to correct identified quality deficiencies. 2. The Administrator will ensure that the facility policies and procedures are consistent with regulatory requirements. 3. Under the direction of the Director of Nursing, residents affected by the deficient practice(s) will be assessed and provided the treatment, services and environment necessary for their health and safety by qualified staff. 4. The quality assessment assurance committee will review implementation of the plans of action periodically to ensure that the plans remain effective. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1. The Quality Assurance Manager will require all sub-committees to turn in meeting minutes	1/13/2017

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

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F 520	Continued From page 18 (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 QAPI (quality assurance, performance improvement) meeting minutes review and staff interview, the facility failed to address all required areas in the QAPI committee. The findings were: Review of QAPI meeting minutes, which included the minutes from the 7/11/16 and 10/10/16 meetings (before and after the call-light and electronic medical record failure), confirmed the facility had a QAPI committee that met each quarter. However, review of the minutes for the 10/10/16 meeting revealed the QAPI committee failed to address the call-light system failure of 8/12/16-8/29/16 or the medical record system failure of 8/12/16-8/15/16. Interview with the Administrator, DON, and Financial Manager on 12/1/16 at 11:15 AM confirmed the QAPI committee failed to address the system failures.	F 520	Continued From page 18 on a monthly basis. All sub-committees will also be required to report out on any identified deficiencies on a quarterly basis. The quality assurance committee will assess the minutes and any other data and develop and implement plans of action to correct identified quality deficiencies. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. All plans of action will be reviewed on a quarterly basis. 2. This plan will be implemented and the corrective action evaluated for its effectiveness. 3. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. Responsible: Quality Assurance Manager.	