

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535054	MULTIPLE CONSTRUCTION A. Building 01 - SCOTT BUILDING B. Wing	DATE OF REVISIT 1/31/2017
NAME OF FACILITY GREEN HOUSE LIVING FOR SHERIDAN	STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0511	01/15/2017	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>8/14/17</i>	DATE	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 1-31-17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/7/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535054	MULTIPLE CONSTRUCTION A. Building 02 - WATT BUILDING B. Wing	DATE OF REVISIT 1/31/2017
NAME OF FACILITY GREEN HOUSE LIVING FOR SHERIDAN	STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC K0511	01/15/2017	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>8/14/17</i>	DATE	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE <i>1-31-17</i>	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/7/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535054	Y1	MULTIPLE CONSTRUCTION A. Building 03 - WHITNEY BUILDING B. Wing	Y2	DATE OF REVISIT 1/31/2017	Y3
NAME OF FACILITY GREEN HOUSE LIVING FOR SHERIDAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0511	01/15/2017	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>9/14/17</i>	DATE	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE <i>1-31-17</i>	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/7/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 535054	Y1	MULTIPLE CONSTRUCTION A. Building 04 - FOUNDERS BUILDING B. Wing	Y2	DATE OF REVISIT 1/31/2017	Y3
NAME OF FACILITY GREEN HOUSE LIVING FOR SHERIDAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0511	01/15/2017	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>[Signature]</i>	DATE	SIGNATURE OF SURVEYOR <i>[Signature]</i>		DATE 1-31-2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/7/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			