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 _____	01/11/2018

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 from 1/8/18 to 1/11/18. The following common abbreviations are used throughout the document: NHA: Nursing Home Administrator Shahbaz: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		2/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/02/2018

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure Advance Beneficiary Notice non-coverage (ABN) was provided to 1 of 1 sample residents (#1) who received Medicare services. The findings were:	F 582	1. Greenhouse Living for Sheridan (GHLS) is unable to correct the deficiency for elder #1. 2. GHLS did not have any other elders receiving Medicare Part A services in the 6-month period reviewed during the	

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F 582	Continued From page 2 1. Medical record review showed Medicare Part A services for resident #1 started on 7/9/17 and ended 7/16/17. The facility mailed the Medicare Non-Coverage (NOMNC) letter to the resident's representative, but there was no evidence the facility provided the ABN notice letter. Interview on 1/10/18 at 4:05 PM with the business office manager stated during this period she was on medical leave and another staff member did the Medicare Beneficiary notifications. She also stated, "This NOMNC letter that was mailed to the patient representative is not normally what I send," and confirmed there was not an ABN letter. 2. Review of the policy and procedure titled "Medicare Part A Beneficiaries Notice of Non-Covered Services" showed "The beneficiary was provided a letter informing the beneficiary of his or her potential liability for payment and related standard claim appeal rights, and another letter conveying service termination due to exhaustion of benefits".	F 582	survey. GHLS does not currently have any elders receiving Medicare Part A services. 3. The Finance/Quality Manager handles notification of elders for Medicare Part A services. In the event the Finance/Quality Manager is not on duty, the facility will train back-up staff to handle notifying elders of discontinuation of Medicare Part A services. On 2/6/18, the Finance/Quality Manager will train the MDS Coordinator and Administrator on the proper procedures for notifying elders of discontinuation of Medicare Part A services including the requirement to provide the Advance Beneficiary Notice of non-coverage (ABN). 4. The Finance/Quality Manager will conduct monthly audits of financial files of elders with Medicare Part A to ensure proper notification. Any negative trends from the monthly audits will be reported to the Quality Assurance Performance Improvement (QAPI) team on a quarterly basis during 2018.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set (MDS) assessment information was an accurate reflection of resident	F 641	1. Elder #8's annual MDS assessment, with an assessment reference date of 11/1/17, has been corrected to show that he did wander during the lookback period. 2. GHLS will conduct a baseline audit of	2/15/18

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F 641	Continued From page 3 status for 1 of 12 sample residents (#8). The findings were: 1. Review of the annual MDS assessment with an assessment reference date (ARD) of 11/1/17 showed resident #8 did not exhibit wandering behaviors. The following concerns were identified: a. Review of the nursing documentation dated 10/26/17 and 10/27/17 showed the resident had wandered in the cottage. Review of nursing documentation dated 10/28/17 at 6:04 PM showed, "Left the building at 4:20 PM and was outside on patio before staff found him/her." b. Interview with the social worker on 1/9/18 at 3 PM revealed her process for determining behaviors for the MDS assessments was to talk with the resident, talk with the staff and review charting. She stated "wandering wasn't in the look back period." Interview on 1/10/17 at 4:10 PM with the social worker revealed the resident did not have a tendency to wander outside. She also stated "Everyone is aware the resident gets up and everyone checks on her/him." c. Interview on 1/10/18 at 2:55 PM with Shahbaz #1 revealed the resident wandered continually and at 2 PM had his/her coat on and wanted to go outside. d. Review of the RAI 3.0 user's manual stated, "The observation or look back period is the time period over which the resident's condition or status is captured by the MDS assessment. The look back period is 7 days from the ARD, and only those occurrences during the look back period will be captured."	F 641	MDS assessments to identify elders that have the potential to wander to ensure that their MDS assessments are properly coded to reflect wandering. 3. The MDS Coordinator in-serviced the Social Worker on 2/2/18 regarding proper coding of wandering on the MDS. 4. The MDS Coordinator will conduct monthly audits of MDS assessments per the MDS schedule to ensure that wandering is properly coded. Monthly audits will begin 2/1/18 and continue during 2018 with the MDS Coordinator submitting quarterly reports outlining any negative trends to the Quality Assurance Performance Improvement (QAPI) team.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/15/18

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F 812	Continued From page 4 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the FDA 2013 food code regulation, the facility failed to ensure tableware was in good repair in 3 of 4 cottages (Scott, Watt, Whitney). The findings were: 1. Observation on 1/9/18 at 10:16 AM showed resident #23 was seated at the dining table in Scott cottage with a plastic drinking glass which had cracks and chips along the upper edge. Further observation of the kitchen area showed 2 plastic beverage glasses by the water urn with vertical cracks which had originated from the upper edge of the glass and created a surface that could not be effectively cleaned. 2. Observation on 1/9/18 at 5:29 PM in Whitney cottage showed 1 of 12 beverage glasses on the	F 812	1. The GHLS Dietary Manager has replaced the plastic drinking glasses that were cracked and chipped. 2. The Dietary Manager has inspected the drinking glasses in all four cottages. Any cracked or chipped plastic drinking glasses were pulled from the shelves and replaced as needed. 3. The Dietary Manager will conduct monthly audits and replace plastic drinking glasses as needed. 4. The Dietary Manager will report monthly audit results with any negative trends to the Quality Assurance Performance Improvement (QAPI)team on a quarterly basis during 2018.	

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F 812	Continued From page 5 dining table during the evening meal had cracks along the upper edge of the container which created a surface that could not be effectively cleaned. 3. Observation on 1/9/18 at 5 PM showed 11 residents were seated at the dining table in the Watt cottage. Four of 11 residents were served drinks in cracked glasses. 4. Interview with the dietary manager on 1/10/18 at 11:10 AM revealed she was aware of the deterioration of the glasses and had been trying to rotate the beverage tableware. According to Food Code 2013, U.S. Public Health Service 4-202.11 "Food-Contact Surfaces. (A) Multiuse Food-Contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."	F 812		