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 _____	02/28/2019

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 2/25/19 to 2/28/19. DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(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. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		4/5/19

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

Electronically Signed | 03/20/2019

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 _____	02/28/2019

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 609	Continued From page 1 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 review of facility incident reports, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were reported for 3 of 4 sample residents (#5, #9, #45) with allegations of abuse or neglect. The findings were: 1. Review of an incident report for resident #5 dated 9/18/18 showed an allegation of neglect was reported to the facility. Further review showed an initial report of the allegation was reported to the State Survey Agency on 9/20/18, 2 days after the allegation occurred and a final report was not completed. 2. Review of an incident report for resident #9 dated 11/24/18 showed an allegation of verbal abuse was reported to the facility. Further review showed an initial report of the allegation was reported to the State Survey Agency on 11/27/18, 3 days after the allegation occurred, the report was rejected back to the facility, and a final report was not completed. 3. Review of an incident report for resident #45 dated 10/1/18 showed an allegation of misappropriation of resident property was reported to the facility. Further review showed an initial report of the allegation was reported to the State Survey Agency on 10/5/18, 4 days after the allegation occurred and a final report was not completed.	F 609	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Social Worker met with the Administrator on March 18, 2019 to review the facilities policies and practices to ensure that protocols for reporting allegations of abuse are current and compliant with regulations. The protocols describe the different agencies and individuals that must be notified at every stage of reporting and the timeframe in which the reporting must occur. 2. The Social Worker notified the Department of Family Services regarding the allegations of abuse or neglect for residents #5, #9, and #45. 3. The Social Worker submitted an HLS/CNA-105 for those involved in the allegations of abuse or neglect for residents #9 and #45. 4. The Social Worker filed a complaint with the State Board of Nursing for those involved in the allegations of abuse or neglect of resident #5. 5. The Social Worker corrected and completed the reports of the allegations to the State Survey Agency for residents #5,	

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 _____	02/28/2019

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 609	Continued From page 2 4. Interview with the administrator and social services director on 2/27/19 at 4:38 PM revealed there was no investigation information available for the allegations and they were unsure what was done for the allegations. 5. Review of the policy titled "Reporting Abuse to State Agencies and Other Entities/Individuals" last revised 7/11/16 showed "...Should a suspected violation of mistreatment, neglect, injuries of an unknown source, or abuse (including Elder to Elder abuse) be reported, the Administrator, or his/her designee, will immediately notify (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)..."	F 609	#9, and #45. How the facility will identify other residents having the potential to be affected by the same deficient practices: 1. The Social Worker will review the 24-hour report and behavior charting daily to ensure any areas of concern regarding potential abuse or neglect allegations are addressed and reported to the appropriate agencies and individuals in the appropriate timeframe. 2. The Social Worker will be available to attend resident council and/or meet with individual residents or their representatives upon request to provide information about the facility policy for reporting allegations of abuse or neglect. 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 Social Worker will conduct a training with staff on the requirements for reporting abuse. 2. The Social Worker will develop a tool to be used when an allegation of abuse or neglect has been made to ensure all appropriate agencies and individuals are notified and that the incident report has been submitted to and accepted by the State Survey Agency. 3. The Social Worker will train the Director	

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 _____	02/28/2019

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 609	Continued From page 3	F 609	of Nursing and Administrator on how to report any allegations of abuse or neglect so they may serve as back-up if the social worker is unavailable. 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 Peformance Improvement (QAPI) program and reviewed quarterly for effectiveness and compliance. 3. The Quality Assurance Manager will conduct audits monthly to ensure that all appropriate agencies are notified and that the allegations have been reported to and accepted by the State Survey Agency when there are allegations of abuse or neglect and that these are done so in the appropriate time frame. Responsible: Social Worker	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		4/5/19

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 _____	02/28/2019

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 610	Continued From page 4 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the 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 review of facility incident reports, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were investigated for 3 of 4 sample residents (#5, #9, #45) with allegations of abuse or neglect. The findings were: 1. Review of an incident report for resident #5 dated 9/18/18 showed an allegation of neglect was reported to the facility. Further review showed there was no evidence an investigation had been completed. 2. Review of an incident report for resident #9 dated 11/24/18 showed an allegation of verbal abuse was reported to the facility. Further review showed 2 staff members were interviewed, however there was no evidence further investigation had been completed. 3. Review of an incident report for resident #45 dated 10/1/18 showed an allegation of misappropriation of resident property was reported to the facility. Further review showed there was no evidence an investigation had been	F 610	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Social Worker met with the Administrator on March 18, 2019 to review the facilities policies and practices to ensure that protocols for investigating allegations of abuse or neglect are current and compliant with regulations. The protocols describe the different steps to be taken during the investigation to ensure a thorough investigation has been conducted. 2. The Social Worker met with resident #5 on 11/18/18 and 2/16/19, resident #9 on 11/28/18 and 2/26/19, and resident #45 on 11/4/18 and 2/2/19 to ensure they were feeling safe and comfortable and that they had no concerns regarding how staff treats them. As part of the quarterly MDS review the Social Worker will continue to follow up with these residents to ensure continued feelings of safety and comfort	

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 _____	02/28/2019

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 610	Continued From page 5 completed. 4. Interview with the administrator and social services director on 2/27/19 at 4:38 PM revealed there was no investigation information available for the allegations and they were unsure what was done for the allegations. 5. Review of the policy titled "Abuse Investigations" last revised 12/20/16 showed "...3. The individual conducting the investigation will, at a minimum: a. Review the completed documentation forms; b. Notify nurse to compled a physical assessment for alleged physical or sexual abuse. c. Review the Elder's medical record to determine events leading up to the incident; d. Interview the person(s) reporting the incident; e. Interview any witnesses to the incident; f. Interview the Elder (as medically appropriate); g. Interview the Elder's Attending Physician as needed to determine the Elder's current level of cognitive function and medical condition; h. Interview staff members (on all shifts) who have had contact with the elder during the period of the alleged incident; i. Interview the Elder's family members, and visitors; j. Interview other Elders whom the accused employee provides care or services; and k. Review all events leading up to the alleged incident..."	F 610	and a lack of concern regarding treatment by staff. How the facility will identify other residents having the potential to be affected by the same deficient practices: 1. The Social Worker will review the 24-hour report and behavior charting daily to ensure any areas of concern regarding potential abuse or neglect allegations are addressed and reported to the appropriate agencies and individuals in the appropriate timeframe. 2. The Social Worker will be available to attend resident council and/or meet with individual residents or their representatives upon request to provide information about the facility policy for investigating allegations of abuse or neglect. 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 Social Worker will develop a tool to be used when an allegation of abuse or neglect has been made to ensure they are following the facility's policies and protocols for conducting a thorough investigation. 3. The Social Worker will train the Director of Nursing and Administrator on how to conduct an investigation for any allegations of abuse or neglect so they	

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 _____	02/28/2019

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 610	Continued From page 6	F 610	may serve as back-up if the social worker is unavailable. 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 Peformance Improvement (QAPI) program and reviewed quarterly for effectiveness and compliance. 3. The Administrator will conduct audits monthly to ensure that thorough investigations have been conducted in compliance with regulations and the facility's policies and procedures.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section;	F 623		4/10/19

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 _____	02/28/2019

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 623	Continued From page 7	F 623		

and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how

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 _____	02/28/2019

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 623	Continued From page 8	F 623		

to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate

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 _____	02/28/2019

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 623	Continued From page 9 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a written transfer notice was issued to 1 of 2 sample residents (#21) who transferred to the hospital. The findings were: 1. Review of a progress note dated 12/26/18 and timed 7:29 PM showed resident #21 was "found on the floor, unresponsive with cyanosis [blueish or grayish color of the skin] noted around lips." Further review showed the resident was transferred to the hospital. There was no evidence a written transfer notice was provided to the resident or the resident's representative. 2. Interview with the administrator on 2/28/19 at 8:21 AM revealed a transfer notice was not issued to the resident at the time of hospitalization. Further interview revealed she was unsure why the notice was not issued.	F 623	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Social Worker, Director of Nursing, and Administrator will meet to review the facility's policies and procedures regarding transfer/discharge notification to ensure they are current and compliant with regulations. 2. The Social Worker met with the representative of resident #21 to review the transfer/discharge notice and educate them regarding their rights surrounding that discharge and who they can contact regarding any disputes. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. The Social Worker will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about the facility's policy regarding notification of transfers/discharges. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:	

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 _____	02/28/2019

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 623	Continued From page 10	F 623	1. The facility has created a form to be used to notify the resident and the resident's representative of the transfer or discharge and the reasons in writing. 2. The Director of Nursing will conduct training with the nurses regarding completing the notice of transfer/discharge form and the requirements for issuing it. 3. The Social Worker will develop a tool to ensure all appropriate steps have been taken and documents issued in the event of a transfer or discharge. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. This plan will be implemented and integrated in to the Quality Assurance Performance Improvement (QAPI) program to evaluate its effectiveness and monitor compliance. 2. The Quality Assurance Manager will conduct monthly audits to ensure compliance with regulations regarding written notification of transfers or discharges. Responsible: Social Worker	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		4/10/19

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 _____	02/28/2019

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 625	Continued From page 11 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a bed-hold policy was issued to 1 of 2 sample residents (#21) who transferred to the hospital. The findings were: 1. Review of a progress note dated 12/26/18 and timed 7:29 PM showed resident #21 was "found on the floor, unresponsive with cyanosis [blueish or grayish color of the skin] noted around lips." Further review showed the resident was	F 625	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The Social Worker, Director of Nursing, and Administrator will meet to review the facility's policies and procedures regarding the notice of bed hold policy to ensure they are current and compliant with regulations.	

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 _____	02/28/2019

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 625	Continued From page 12 transferred to the hospital. There was no evidence the resident and the resident representative were provided written notice of the bed hold policy. 2. Interview with the administrator on 2/28/19 at 8:21 AM revealed a written bed-hold policy was not issued to the resident or the resident's representative at the time of hospitalization. Further interview revealed she was unsure why bed-hold policy was not issued.	F 625	2. The Social Worker met with the representative of resident #21 to review the bed hold notice and educate them regarding their rights surrounding that policy. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. The Social Worker will be available to attend Resident Council and/or meet with individual residents or their representatives upon request to provide information and support about the facility's policy regarding notification of bed hold upon transfer. 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 facility has created a form to be used to notify the resident and the resident's representative of the bed hold policy in writing. 2. The Director of Nursing will conduct training with the nurses regarding completing the bed hold notification before/upon transfer. 3. The Social Worker will develop a tool to ensure all appropriate steps have been taken and documents issued in the event of a transfer or discharge. How the facility plans to monitor its	

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 _____	02/28/2019

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 625	Continued From page 13	F 625	performance to make sure that solutions are sustained: 1. This plan will be implemented and integrated in to the Quality Assurance Performance Improvement (QAPI) program to evaluate its effectiveness and monitor compliance. 2. The Quality Assurance Manager will conduct monthly audits to ensure compliance with regulations regarding written notification of transfers or discharges. Responsible: Social Worker	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		3/22/19

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 _____	02/28/2019

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 755	Continued From page 14 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy and procedure review, the facility failed to ensure medications available for use were not expired in 2 of 4 medication storage areas, cottages (Whitney, Founders). The findings were: 1. Observation of Whitney cottage in room 309 medication storage on 2/27/19 at 11 AM showed a 41 count bubble package of acetominophen 500 mg expired 1/1/19. Interview at that time with RN #1 confirmed the medication was expired, and was available for resident use. 2. Observation of Founders cottage in room 410 medication storage on 2/27/19 at 11:51 AM showed a tube of nystatin-triamcinolone topical expired on 01/2019, and a tube of 0.05% fluocinonide topical expired 9/2018. Observation of Founders cottage in room 405 medication storage on 2/27/19 at 12:02 PM showed a bottle of Debrox ear wax removal 1/2 fluid ounce expired on 10/19/18, in addition a bottle of saline nasal spray 3 fluid ounce expired 12/18. Interview with RN #2 on 2/27/19 at 12:02 PM confirmed the medications were expired and were available for	F 755	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. Acetaminophen 500mg tables from room 309 were removed and destroyed on 2/28/2019. 2. Nystatin topical and fluocinonide topical were removed from room 410 and destroyed on 2/28/2019. 3. Debrox ear wax removal fluid and saline nasal spray were removed from 405 and destroyed on 2/28/2019. 4. The Administrator and Director of Nursing (DON) met on 3/18/19 to review the facility's policies and practices for identifying and destroying expired medications to ensure they are in compliance with current regulations. How the facility will identify other residents having the potential to be affected by the	

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 _____	02/28/2019

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 755	Continued From page 15 resident use. 3. Interview with the ADON/MDS coordinator on 2/28/19 at 9:50 AM revealed that it was the facilities expectation for expired medications to be exchanged with new medications each month. 4. Review of the policy titled " Storage of Medications" dated December 2011 showed "...4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..."	F 755	same deficient practice: 1. All 48 individual medication cabinets were checked by DON and MDS Coordinator on 3/1/2019 for expired medications. 2. Storage cabinets in the four nursing offices were checked by DON and MDS Coordinator on 3/1/2019 for expired stock medications. 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 DON or designee will educate nursing staff on the proper storage and labeling of medications by 3/22/2019. 2. Nursing staff will check all medications for expiration dates, both in resident rooms and nursing offices, during monthly pharmacy change-over. All expired medications will be removed and destroyed according to GHLS policy and procedures. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. DON or designee will audit 5 resident rooms and one nursing office after each monthly change-over for expired medications. Corrective action will be taken as necessary for any identified concerns.	

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 _____	02/28/2019

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 755	Continued From page 16	F 755	8. The QAPI Committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. Responsibility: Director of Nursing	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		3/22/19

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 _____	02/28/2019

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 758	Continued From page 17 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure documentation of the rationale for not implementing a gradual dose reduction (GDR) was obtained for 1 of 5 sample residents (#6) reviewed for medication use. The findings were: 1. Review of the physician orders showed resident #6 was ordered quetiapine fumarate (antipsychotic) 25 mg by mouth twice per day on 2/21/17. The following concerns were identified: a. Review of the medical record showed a GDR for quetiapine fumarate was recommended on 12/1/18, 12/18/18, 2/1/19, and 2/21/19 and the physician indicated the reduction was contraindicated; however, the facility was unable to provide documentation of a rationale for continued use at the higher dose.	F 758	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. A GDR request was initiated for resident #6 on 3/19/19. 2. The Administrator, DON, and Consulting Pharmacist met on 3/19/19 to review the facility's policy regarding monitoring residents on antipsychotics to ensure compliance with current regulations. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. All residents currently on antipsychotics	

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 _____	02/28/2019

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 758	Continued From page 18 2. Interview with the DON on 2/27/19 at 4:44 PM revealed the pharmacist would occasionally recommend a GDR or risk benefit; however, the providers "generally ignore it." Further, she confirmed the facility's policy was for an annual GDR to be performed.	F 758	were identified during monthly meeting with DON and Consulting Pharmacist on 3/19/19. GDR requests were initiated on all Elders receiving antipsychotics. 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. All residents receiving psychotropic medications will be reviewed quarterly by the DON and consultant pharmacist during their monthly regimen review meeting and GDR requests will be initiated according to CMS regulations. If the GDR is denied by the physician, Green House Living for Sheridan will ensure that a rationale for that denial is documented in the chart. 2. MDS Coordinator will monitor for GDRs during each residents quarterly assessment and results of that audit will be brought to monthly regimen review with consultant pharmacist. 3. During monthly physician rounding GDRs will be reviewed for completeness of the physician□s rationale. 4. DON will chart GDR assessment in ECS monthly on those Elders identified as due for an evaluation. How the facility plans to monitor its performance to make sure that solutions are sustained:	

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 _____	02/28/2019

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 758	Continued From page 19	F 758	1. MDS Coordinator will perform a chart audit to ensure presence of GDR Request upon completion of each quarterly assessment of anyone currently on an antipsychotic. Corrective action will be taken as necessary for any identified concerns. 2. The QAPI Committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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;	F 880		4/10/19

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 _____	02/28/2019

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 880	Continued From page 20 §483.80(a)(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; (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 _____	02/28/2019

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 880	Continued From page 21 §483.80(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 review of the infection prevention and control program and staff interview, the facility failed to ensure an infection prevention and control program was implemented. The census was 43. The findings were: Review of the facility infection prevention and control program showed the facility tracked residents that were prescribed antibiotics. There was no evidence the facility had a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Interview with the DON on 2/27/19 at 4:10 PM revealed the facility had an infection prevention system built into the computer system; however, she confirmed the facility had not utilized the system correctly. Further interview revealed she had started on 2/24/18 and identified the system was not in place and was working on updating it.	F 880	How the corrective action(s) will be accomplished for those resident found to be affected by the deficient practice: 1. Infection prevention policies, procedures, and surveillance that the facility had previously had in place have been re-instituted as of 2/25/2019. 2. Administrator, DON, and MDS Coordinator will meet 3/22/19 to review the facility's policies and practices regarding infection prevention to ensure compliance with current regulations. How the facility will identify other residents having the potential to be affected by the same deficient practices. 1. DON and MDS Coordinator began monitoring the 24-hour report daily starting 2/25/19 to watch for newly symptomatic residents and implemented appropriate nursing interventions during daily nursing meetings as appropriate. 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. Infection Preventionist will hold monthly Infection Prevention meetings with key staff to discuss any current issues.	

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 _____	02/28/2019

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 880	Continued From page 22	F 880	2. DON and MDS Coordinator will monitor 24-hour reports daily for newly symptomatic residents and discuss implementation of appropriate nursing interventions during daily nursing meeting. 3. Infection Preventionist will track residents on antibiotics through the facility's electronic charting system and hospital Cerner system to ensure appropriate antibiotic prescribing and use. How the facility plans to monitor its performance to make sure that solutions are sustained: 1. DON or designee will conduct monthly audits of the infection prevention programs to ensure appropriate antibiotic prescribing and usage and thorough documentation are present in the resident's chart. 2. DON will report quarterly to the QAPI Committee trends identified regarding infections. The QAPI Committee will evaluate the effectiveness of the plan and implement additional interventions as needed to ensure continued compliance. Responsible: DON/Infection Preventionist	