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

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 _____	01/15/2020

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 1/12/20 to 1/15/20. The following common abbreviations are used throughout the document: ADON: Assistant Director of Nursing BIMS: Brief Interview for Mental Status DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set mg: milligram NHA: Nursing Home Administrator Shahbaz: Certified Nursing Assistant Shahbazim: Certified Nursing Assistants Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 641 SS=B	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 medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the MDS assessment was an accurate reflection of resident status for 1 of 13 sample residents (#5) reviewed. The findings were: 1. Review of the 12/31/19 quarterly MDS	F 641	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The MDS Coordinator will perform a review of the RAI manual, Chapter 3, Section N, specifically page N-7 to ensure proper understanding of coding. An MDS Correction will be submitted for Elder who was improperly coded as having received anticoagulant medication every day of the 7*day look-back period. How the facility will identify other resident having the potential to be affected by the same deficient practice: 1. The MDS Coordinator will conduct an audit of all Elders on antiplatelet medications to ensure proper coding and submit any corrections as necessary.	02/28/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Craig	Administrator	2/7/2020

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.

This plan of correction was accepted with the agreed upon change with Michelle Craig, NHA, on 2/18/20 at 2:06 PM Jean Jennie

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 _____	01/15/2020

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 641	Continued From page 1 assessment showed resident #5 received an anticoagulation medication every day of the 7-day look-back period. The following concerns were identified: a. Review of the most current physician orders showed the resident was prescribed clopidogrel bisulfate (an antiplatelet medication), 75 mg daily for "prevention" with a start date of 5/29/13. Further review showed the resident was not prescribed an anticoagulant. b. Interview with the MDS coordinator on 1/14/20 at 2 PM confirmed the resident's medications did not include an anticoagulant. In addition she was unaware clopidogrel bisulfate (Plavix) was not coded as an anticoagulant. 2. Review of MDS 3.0 RAI Manual version 1.15 page 478: Section N0410E, Anticoagulant (e.g. warfarin, heparin, or low-molecular weight heparin): showed: "Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here."	F 641	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. MDS Coordinator will create a tool to be used when completing an MDS for an Elder on antiplatelet medication to verify accurate coding prior to submission of the MDS. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly audits of any MDS submitted for Elders on antiplatelet medications to ensure accuracy of the information transmitted. This template uses 11-point font. You may use larger or smaller font if you choose. Responsible: MDS Coordinator	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		

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 _____	01/15/2020

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 656	Continued From page 2 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive person-centered care plan for 1 of 13 sample residents (#5). The findings were: 1. Review of the 12/31/19 quarterly MDS assessment showed resident #5 had a BIMS score of 6/15 (severe cognitive impairment) and diagnoses which included CVA (cerebrovascular accident); TIA (transient ischemic attack), or	F 656	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. The MDS Coordinator will update the individualized care plan to reflect the current diet orders immediately. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. The MDS Coordinator, Consultant Dietician, and Dietary Mentor will cross reference, review, and audit each individual diet and care plan to ensure that they are consistent for all Elders.	02/28/2020

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 _____	01/15/2020

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 656	Continued From page 3 stroke; hemiplegia or hemiparesis; and dysphagia. Further review showed the resident had a swallowing disorder coded as loss of liquids/solids from the mouth and had a mechanically-altered diet. Review of the physician's orders showed the resident was prescribed a regular soft diet with extra moisture, ground meats, and nectar-like liquids on 4/11/19. Review of a SLP (speech language pathologist) swallowing precaution document dated 10/23/18 showed the recommended diet consistency was soft with extra moisture and the recommended liquid consistency was nectar. The following concerns were identified: a. Review of the care plan last revised 1/4/20 showed the resident ate with supervision, had food cut-up, and ground meats with extra moisture. Further review of the entire care plan failed to show an individualized plan had been developed to address the resident's need for thickened liquids. b. Interview on 1/14/20 at 2 PM with the ADON/MDS coordinator confirmed a care plan had not been developed to include the resident's need for thickened liquids.	F 656	2. Dietary Mentor will educate staff on any discrepancies found between dietary orders and care plans to ensure proper understanding of the dietary needs of each Elder. 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. Diet orders will be reviewed every three months for each Elder per the MDS schedule at the monthly significant change meeting. Any changes will be recorded in real time in the individualized care plan and diet order section of the EMR. Dietary Mentor will inform staff of any changes as they occur. 2. MDS Coordinator will develop a tool to ensure all the appropriate steps have been taken to update the care plan, diet orders, and inform staff. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly audits per the MDS schedule to ensure the accuracy and matching of the care plan and diet orders. Responsible: MDS Coordinator	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

34

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 _____	01/15/2020

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 686	Continued From page 4 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure the treatment of pressure ulcers was provided under the guidance of a physician for 1 of 2 sample residents (#29) with pressure ulcers. The findings were: 1. Review of the 12/11/19 quarterly MDS assessment showed resident #29 was admitted to the facility on 4/26/16 and had diagnoses which included hypertension, diabetes mellitus, depression, acute kidney failure, dyspnea, and paroxysmal atrial fibrillation. Further, the resident required the extensive assistance of 2 staff members for bed mobility, transfers, locomotion on unit, dressing, toilet use, personal hygiene, and bathing. The resident was identified as being at risk for pressure ulcers/injuries, and was documented to have one unhealed stage 3 pressure ulcer/injury, which was acquired at the facility. The following concerns were identified: a. Review of a general skin assessment progress note dated 9/16/19 and timed 1:02 PM showed a "reddened" area surrounding wound tissue of "pink/ yellow slough" was identified, and was classified as a "Mosture" [sic] type wound on the "coccyx, Gluteal cleft split." The physician was notified via fax on 9/16/19 identifying this issue, stating "Open area to gluteal cleft R/T [related to] mositure [sic] - monitoring." There was no evidence of physician response or fax receipt confirmation. b. Observation on 1/14/20 at 8:44 AM showed	F 686	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. Nursing staff will complete an additional full skin assessment and wound assessment of the identified pressure ulcer injury and document findings in EHR. 2. Attending physician will be notified of findings and visit with Elder in person regarding wound status and provide wound care recommendations. 3. Orders and/or wound care instructions received will be documented in the Elder's EMR and will be added to the nursing flow sheets as appropriate. 4. Administrator and DON will review the facilities policies and practices regarding wound care and prevention to ensure they are in compliance with current regulation requirements. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. DON and MDS Coordinator will perform an audit of all wounds present within the facility and ensure that physician notification has been sent and confirmation of such notification is received and documented in Elder's physical chart or EHR. 2. Orders and/or wound care instructions received will be documented in the Elder's EMR and will be added to the nursing flow sheets 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. DON will create a tool to track the monitoring and communications regarding wound presence and status and use this tool to conduct audits weekly to ensure compliance 2. DON will review facilities wound care policy, update as appropriate, and educate nursing staff at the next nursing staff meeting. 3. MDS Coordinator and designated wound nurse will attend wound care education and obtain Wound Care Certification.	02 28 2020

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 _____	01/15/2020

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 686	Continued From page 5 RN #3 and Shahbaz #5 provided wound care to the resident. When staff rolled the resident onto his/her right side there was no dressing present covering the wound. The RN identified the wound to be addressed was in the sacral area, below the gluteal cleft, and above the coccyx. The area around the wound was reddened and irritated. The wound was the size of a nickel, with edges that were white and pink in color. The center of the wound was an open hole the size of a dime, with some slight undermining observed. c. Review of the 9/16/19 to 1/14/20 current and discontinued MAR (medication administration record) and TAR (treatment administration record) showed no evidence of care/treatment orders from the physician for the identified wound/areas of concern. d. Review of physician progress notes for all visits occurring after the initial notification of the pressure ulcer on 9/16/19 showed dates of service 10/7/19, 12/6/19, and 1/6/20; these notes showed no documentation addressing pressure ulcers or other skin issues/concerns. The physician notes from 10/7/19 and 12/6/19 identified the resident's skin as "Warm and dry without any rash." Further review showed the progress note on 1/6/20 did not contain documentation of a skin assessment. e. Review of the nursing progress notes from 9/16/19 through 1/14/20 showed inconsistent treatment of the wound. Further, the documentation identified numerous changes in the status of the wound, including tissue breakdown, drainage, and an increase of pain to these areas identified by the resident. There was no evidence the physician was notified with any of these changes of condition. f. Interview with RN #1 on 1/14/20 at 3:55 PM revealed she was not aware of any staff member	F 686	4. Educator and wound care certified staff will provide annual education to staff. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly audits to ensure all wound documentation has occurred as per facility policy. Responsible: DON	

JH

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 _____	01/15/2020

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 686	Continued From page 6 that was wound care certified, but thought perhaps the DON might be. She revealed they followed the facility's "Standing Orders" for wound care. Further, the facility did not perform wound care until a physician provided the staff with orders; however, if the resident did not have orders for wound care, staff "just treat it [the wound] using what knowledge they have or what they've done before" and "if the dressing came off prior to my shift, I wouldn't know what dressing was on there or what they had done before." Further, she "would just use her best judgement and the supplies they had on hand at the facility." g. Review of the facility's "Standing Orders" document, undated, showed for "wound": "Culture if signs/symptoms of infection present. Consult GHLS [facility] Wound Nurse for treatment." h. Interview with RN #2 on 1/15/20 at 10:35 AM revealed she was not aware of any staff member that was wound care certified. The RN provided charting documentation which showed a list of tasks to perform/monitor/document on during her shift. One task addressed the resident's pressure ulcer, with interventions/treatments listed and an implementation date of 10/27/19. The RN stated the details listed were not orders and "just what they [nursing management] recommend we do, but we kinda just use our own judgement." i. Interview with the DON on 1/15/20 at 9:39 AM revealed when an issue was identified such as a bruise, skin tear, or pressure ulcer, her expectation was for staff to "put it on their charting 'to-do' list so that staff know to monitor the change in condition." In addition, "if there is something more severe than a bruise, the provider should be notified." The DON also expected staff to provide treatments based on nursing judgement, unless there were orders. In	F 686		

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 _____	01/15/2020

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 686	Continued From page 7 addition, wound care consultations were utilized on an individualized basis and based on the situation. If any of these issues arose, she would "assume there would be a fax or something that shows the provider was notified, or that he said something in his progress notes." j. Review of the "Wound Care" policy, updated July 2012, showed "..The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation - 1.Verify that there is a physician's order for this procedure. 2. Review the Elder's care plan to assess for any special needs of the Elder." k. Review of an undated "Nurse Notification of Physician" policy showed "It is the responsibility of licensed nurses employed in this community to notify the resident's physician when the resident's clinical condition may require or requires physician intervention."	F 686		
F 755 SS=D	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	F 755		

JY

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 _____	01/15/2020

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 8 must employ or obtain the services of a licensed pharmacist who- §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 cottages (Scott, Watt). The findings were: 1. Observation of the Scott cottage nurse's station medication storage area on 1/14/20 at 3:15 PM showed the following concerns: a. Two GlucaGen 1 mg Hypokits had an expiration date of 12/28/19. b. 48 caplets of Leader Anti-Diarrheal medication had an expiration date of 9/2019. c. Five bisacodyl 10 mg suppositories had an expiration date of 7/2019. d. One bisacodyl 10 mg suppository had an expiration date of 4/2018. 2. Observation of the Watt cottage nurse's station medication storage area on 1/14/20 at 4 PM showed nine bisacodyl 10 mg suppositories had an expiration date of 6/2019.	F 755	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. 2 GlucaGen 1 mg Hypokits from Scott Cottage Nurse's Station were removed and destroyed on 1/15/2020. 2. 48 caplets of Leader Anti-Diarrheal medication from Scott Cottage Nurse's Station were removed and destroyed on ~~1-1-2020~~ 1/15/2020 JY 3. 5 bisacodyl 10mg suppositories from Scott Cottage Nurse's Station were removed and destroyed on 1/15/2020. 4. 9 bisacodyl 10mg suppositories from Watt Cottage Nurse's Station were removed and destroyed on 1/15/2020. 5. The Administrator and Director of Nursing met on 1/17/2020 to review the facility's policies and practices for identifying and destroying expired medication to ensure they are in compliance with current regulations. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. All 48 individual medication cabinets were checked by DON on 1/17/2020 for expired medications. 2. Storage cabinets in the four nursing offices were checked by DON on 1/17/2020 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:	02/28/2020

JY

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

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 _____	01/15/2020

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 9 3. Interview on 1/15/20 at 10:19 AM with the DON revealed it was the facility's expectation for the nurse to not administer expired medications and to destroy all expired medications. 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	1. The DON or designee will educate nursing staff on the proper storage and labeling of medications. 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. 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 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of	F 801	Responsible: DON	

JY

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 _____	01/15/2020

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 801	Continued From page 10 supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and	F 801		

SY

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 _____	01/15/2020

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 801	Continued From page 11 (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of enrollment letter, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 46. The findings were: Interview with the dietary mentor on 1/12/20 at 3:13 PM revealed she had been hired in March of 2019. Further, she was enrolled in the "Nutrition & Foodservice Professionals Training Course" through the University of North Dakota with an expected completion date of April 2020. Review of the enrollment letter showed the dietary mentor enrolled in the course on 5/2/19.	F 801	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice. 1. Administrator reviewed facility's policy regarding dietary personnel to ensure accuracy and compliance with current regulations. 2. Facility demoted Dietary Mentor to CDM-in-training until she has received her certification. 3. Facility already had an employee on staff with a current CDM certification. This employee was promoted to Dietary Manager 1/16/2020 and has agreed to serve as such until the CDM-in-training has received her certification or a new employee that meets the current regulatory requirements has been hired. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. CDM and Consultant Dietician will conduct an audit of all 48 Elder's dietary orders to ensure they are accurate and appropriate. 2. CDM will educate CDM-in-training and direct care staff on any changes made as necessary. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not occur: 1. If the facility finds itself in the position of needing to hire a full-time nutrition professional it will have it's consultant dietician or hire temporary agency personnel who meet regulatory requirements to fill that position in the interim until a full-time employee who meets the regulatory training requirements has been hired. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly check-ins with the HR Manager to ensure the facility is currently meeting the regulatory requirements for the nutrition professional position. Responsible: Human Resource Manager How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:	01 31 2020 02 28 2020
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, product label and direction information review, medical record	F 808		

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 _____	01/15/2020

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 808	Continued From page 12 review, and staff interview, the facility failed to ensure residents received food in the appropriate form as prescribed by the physician for 1 of 2 sample residents (#5) with a mechanically-altered diet. The findings were: 1. Review of the 12/31/19 quarterly MDS assessment showed resident #5 had a BIMS score of 6/15 (severe cognitive impairment) and diagnoses which included CVA (cerebrovascular accident), TIA (transient ischemic attack), or stroke; hemiplegia or hemiparesis; and dysphagia. Further review showed the resident had a swallowing disorder coded as loss of liquids/solids from the mouth and had a mechanically-altered diet. Review of the physician's orders showed the resident was prescribed a regular soft diet with extra moisture, ground meats, and nectar-like liquids on 4/11/19. Review of a SLP (speech language pathologist) swallowing precaution document dated 10/23/18 showed the recommended diet consistency was soft with extra moisture and the recommended liquid consistency was nectar. The following concerns were identified: a. Observation on 1/12/20 at 4:59 PM showed Shahbaz #1 prepared thickened water for the resident by pouring a premeasured packet of thickening powder into a beverage glass and adding water. The Shahbaz mixed the powder into the water by swirling it with a straw and then served it to the resident. The glass of water appeared separated with clear liquid sitting above the cloudy liquid. At 5:24 PM the resident was served a meal of mechanically-altered ground beef on a bun, cooked mixed vegetables, and a bag of potato chips. At 5:30 PM the activities coordinator assisted the resident by opening the bag of potato chips. At 5:34 PM the resident was	F 808	1. DON will discuss current food and liquid consistency diet orders with Elder #5 and/or their representative. DON will educate Elder and/or representative on the possible risks involved with altering the current orders if the Elder prefers. The physician will be notified of the Elders preferential dietary alterations. 2. The Administrator and DON will review the facilities policies and practices regarding therapeutic diets and Elder rights to ensure they are in compliance with current regulatory requirements. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. DON, Consultant Dietician, and Dietary Mentor will review the need for, and Elder acceptance of, all prescribed therapeutic diets and individualized modification. 2. DON will educate Elder and/or representative on the possible risks involved with altering the current orders if the Elder prefers. The physician will be notified of the Elders preferential dietary alterations. 3. Dietary Mentor will educate staff on the proper preparation of thickened liquids and usage of the thickening agents. 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. Therapeutic diets will be reviewed at the monthly significant change meeting to ensure they continue to be medically indicated. 2. The DON will create a tool to monitor therapeutic diet alteration education, communication with medical professionals, and documentation in EHR. 3. The Educator and Dietary Mentor will work to create an annual and new hire orientation training for staff regarding thickened liquid preparation and therapeutic diets. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly audits to ensure those requesting therapeutic diet alterations have been educated, the physician, has been notified, and proper documentation in the EHR has occurred. Responsible: DON	

SJ

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 _____	01/15/2020

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 808	Continued From page 13 observed eating the potato chips and drinking the separated water with a straw. b. Observation on 1/13/20 at 8:44 AM showed Shahbaz #2 served the resident a cup of unthickened coffee and a beverage glass of thickened water which appeared separated. Interview at that time with the Shahbaz revealed the facility does not thicken the resident's coffee and stated the water always separated and needed to be stirred periodically. c. Observation on 1/14/20 at 11 AM with the dietary mentor and Shahbaz #2 showed approximately 7 ounces of water was placed in a beverage glass and the premeasured thickening powder was then added. The water separated with a clear layer above a cloudy layer. 5 ounces of water was then placed in a beverage glass and the thickening powder was added to the liquid and stirred. This water showed no separation. Interview at this time with Shahbaz #2 revealed the facility added extra water to the beverage glass to thin it down because the resident would not drink it and often poured it out if it was at a nectar-like consistency. d. Interview on 1/14/20 at 11 AM with the dietary mentor revealed the facility did not thicken coffee because the thickening powder did not work in hot liquids. In addition, she stated the resident should have been offered mashed potatoes instead of potato chips and the liquids should be served at the physician-prescribed consistency. e. Interview on 1/14/20 at 1:55 PM with the DON revealed food and liquid consistency was the resident's choice; however, there was no evidence the physician had been notified or the resident's representative educated of the risks involved.	F 808		

SY

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 _____	01/15/2020

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 808	Continued From page 14 2. Review of the "Hormel Thick & Easy" instant food and beverage thickening powder product instructions showed: "Add 1 packet (5.2g) to 4 fl oz [fluid ounces] of liquid and stir for 15 seconds. Allow 1-4 minutes for liquid to reach optimal thickness. The amount of thickener may need to be adjusted to meet your individual needs. Thick and Easy instant food & beverage thickening powder can be used to thicken hot or cold beverages or foods. Results will vary depending on type and temperature of beverages or foods."	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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, review of food temperature logs, review of the U.S. Public Health Service Food Code, and review of policy	F 812	How the corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: 1. Administrator and Dietary Mentor reviewed the facility's policies and practices to ensure compliance with current regulatory requirements surrounding food storage, labeling, and temperatures.	02 28 2020

JY

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 _____	01/15/2020

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 812	Continued From page 15 and procedure, the facility failed to ensure food temperatures were taken prior to service in 1 of 4 cottages (Founders). In addition the facility failed to ensure food was properly stored in 2 of 4 cottages (Founders, Scott). The findings were: Related to food storage: 1. Observation on 1/12/20 at 3:57 PM of the freezer located in Scott cottage showed the following concerns: a. One plastic storage bag contained an open bag of sausage pizza topping in which the sausage had spilled out of the original bag and showed visible frost build-up on the meat. In addition, the plastic storage bag was not labeled with an open or use-by date. b. One plastic storage bag of what appeared to be chicken breasts had a build-up of frost on the meat. In addition, the plastic storage bag was unlabeled and undated. c. One plastic storage bag of what appeared to be breaded fish chunks was unlabeled and undated. d. One plastic storage bag was labeled as "cream puffs" and had a date of use as "Friday." e. One plastic storage bag of breadsticks had a visible build-up of frost on the bread. The bag was unlabeled with a date of 10/15/19 and showed "for Thursday." f. One open bag of mixed vegetables was in the original package and was not labeled with an open date or use-by date. 2. Observation on 1/13/20 at 8:49 AM of the freezer located in the Founder's cottage showed the following concerns: a. One plastic storage bag of what appeared to be egg rolls had a build-up of frost on the inside of the bag. In addition, the bag was	F 812	2. Dietary Mentor went through food storage areas in Founders and Scott kitchens to ensure proper labeling and storage had occurred and removed any items that were not properly labeled and stored. How the facility will identify other residents having the potential to be affected by the same deficient practice: 1. Dietary Mentor went through food storage areas in Watt and Whitney kitchens to ensure proper labeling and storage had occurred and removed any items that were not properly labeled and stored. 2. Dietary Mentor will conduct in-services regarding food storage, labeling, and temperature taking/logging. 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. Dietary mentor will conduct weekly audits of each cottages food storage areas to ensure proper labeling, storage, and discarding of expired foods. 2. Dietary Mentor will conduct weekly audits of food temperature logs to ensure they are properly maintained. 3. Dietary Mentor or designee will conduct random meal audits weekly to ensure proper kitchen procedures are being followed during meal preparation and service. 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 and reviewed quarterly for effectiveness and compliance. 3. The QA Manager will conduct monthly audits to ensure food labeling, storage, and temperature monitoring/documentation is occurring. Responsible: Dietary Mentor	

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 _____	01/15/2020

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 812	Continued From page 16 unlabeled and undated. b. One plastic storage bag of what appeared to be asparagus pieces was unlabeled and undated. 3. Interview with the dietary mentor on 1/12/20 at 5:47 PM confirmed food stored should be labeled and dated. In addition, she stated monitoring of the freezers was her responsibility. 4. Review of the policy "Storage of Food and Supplies" dated December 2011 showed "Food Labeling and Expiration Guidelines 2. All food shall be appropriately labeled and dated to ensure proper FIFO [first in first out] rotation by expiration dates. Expiration dates on unopened food will be observed. Labels need to include: ...b. Opened containers - "opened" dates. Shahbazim are trained in the "7 Day Rule" and shorter storage limits for other items. Food are monitored and discarded if they pass by these time limits. 3. Food Coordinators and the Dietary Mentor will be responsible for monitoring food items in pantry, refrigerators, and freezers for expired or past perish dates..." 5. According to Food Code 2017, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a	F 812		

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 _____	01/15/2020

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 812	Continued From page 17 temperature of 5°C (41°F) or less for a maximum of 7 days." Related to food temperatures: 1. Observation on 1/13/20 at 11:59 AM showed Shahbaz #3 was preparing the noon meal in Founder's cottage. The Shahbaz failed to obtain the temperature of the regular food and the mechanically altered food prior to plating and serving the food to the residents. Review of the food temperature log for 1/13/20 showed no food temperatures had been recorded for the noon meal. 2. Observation on 1/14/20 at 11:55 AM showed Shahbaz #4 was preparing the noon meal of chicken strips, mixed vegetables, french fries, and berries with cream in Founder's cottage. The following concerns were identified: a. Observation of the meal preparation showed Shahbaz #4 failed to measure the temperature of the regular food and the pureed food prepared for resident #2 prior to serving the residents. Interview with the Shahbaz on 1/14/20 at 12:17 PM revealed she had taken the temperature of the hot food while it was in the oven and she used the digital temperature display on the outside of the refrigerator to check the temperature of the cold food. However, review of the food temperature log for 1/14/20 showed no food temperatures had been recorded for this meal. 3. Review of the food temperature log sheets from 1/1/20 through noon of 1/14/20 showed temperatures were not recorded for 26 of the possible 41 meals served. In addition, the log sheet did not provide a section to record the temperature of the mechanically-altered foods.	F 812		

SY

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 _____	01/15/2020

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 812	Continued From page 18 4. Interview with the dietary mentor on 1/14/20 at 10:26 AM confirmed temperatures of the food should be taken prior to service and more staff education was needed. 5. Review of the undated policy "Food Temperatures at Serving" showed "1. All hot foods items will be served to the resident at the temperature of a least 140 degrees F...4. All cold foods will be served to the resident at a temperature of 40 degrees F." 6. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5°C (41°F) or less.	F 812		