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 _____	11/17/2022

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 11/14/22 to 11/17/22. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status DON- Director of Nursing IP- Infection Preventionist LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set MG- Milligrams PPE- Personal Protective Equipment RN- Registered Nurse Shahbaz- Certified Nurse Aide Shahbazim- Certified Nurse Aides TAR- Treatment Administration Record QAPI- Quality Assurance Performance Improvement Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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.	F 623		12/9/22

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

Electronically Signed | 12/11/2022

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 _____	11/17/2022

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 1	F 623		

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; 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,

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 _____	11/17/2022

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 2	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how 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

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 _____	11/17/2022

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 3 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure elders or elders' representatives received a written transfer notice for 1 of 1 sample elder (#26) reviewed for hospitalization. The findings were: 1. Review of a progress note dated 11/9/22 and timed 9:15 AM showed elder #26 was a direct admit to the hospital for placement of a PICC (peripherally inserted central catheter) line and was scheduled for surgical debridement of a left leg post-surgical wound. The following concerns were identified: a. Review of the medical record showed no evidence a written transfer notice was provided to the elder, or elder's representative at the time of transfer. b. Interview with the DON on 11/17/22 at 10:31 AM revealed the elder went to a physician visit and returned to the facility for 1 night. After returning to the facility, the physician notified the facility the elder needed to be sent to the hospital for admission. The elder was sent to the hospital the day after the physician visit. c. Interview with LPN #1 on 11/17/22 at 11:30 AM confirmed she was the nurse that prepared documents for the elder at the time of the transfer. Further interview revealed she did not provide a written transfer/discharge notice to the elder or the elder's representative at the time of the elder's transfer.	F 623	Tag: 0623-483.15(c)(3)-(6)(8) Notice Requirement Before Transfer/Discharge 1. Elder 26, The Clinical Support Team, Licensed Nurse, LPN spoke to family and Hospital regarding Elders condition in preparation for Transfer. They were informed verbally prior to discharge of the transfer. Director of Nursing met with Responsible Party and discussed Transfer and Bed hold but did not document it in chart. All elders, including elder #26, have the potential to be effected by this issue. 2. Medical Records performed an Audit to ensure no other residents were deficient in the documentation for Transfers/Discharge. No other charts or elders reflected lack of documentation for transfer/bed hold. Medical Records Designee will perform audits on transfer/discharge on all charts after each event. 3.Training has been provided to all Licensed Nurses by Infection Control Preventionist, LPN regarding the Policy & Procedure in Transfer/Discharge of an Elder at GHLS. Documentation review with Licensed nurses was completed and	

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 _____	11/17/2022

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 4 2. Review of the policy titled "Notice of a Transfer and/or Discharge" dated December 2011 showed "...1. Except as specified below, an Elder, and/or his or her representative (sponsor) will be given a thirty (30)-day advance notice of an impending transfer or discharge from our facility:...f. An immediate transfer or discharge is required by the Elder's urgent medical needs;...2. The Elder and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; The location to which the Elder is being transferred or discharged; d. The name, address, and telephone number of the state long-term care ombudsman; e. The name, address, and telephone number of each individual or agency responsible for the protection and advocacy of mentally ill or developmental disabled individuals (as applies); and f. The name address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices..."	F 623	ensured to remain in each nurses station as a notation of reminder to follow the documents procedure for all transfers and discharges. On 12/8/22 the training was completed on 12/8/22 to licensed staff. In addition, the Policy was provided for each to review and an opportunity to ask questions. Covered in the training is reasons for transfer or discharge, location of transfer or discharge. Including the Ombudsman with name, phone number. State telephone number and appeals process. 4. Monthly and report to the Quality Assurance committee the audits outcome. In the event a transfer/discharge document is not present after a transfer/discharge, the MRD is to immediate inform the Director of Nursing and in his/her absence the Clinical Support Team member who did not complete this process. Then alert the Administrator of the follow up in writing. This shall then go to QA for Root cause analysis. 5. Quality Assurance Team will review for compliance. This practice shall continue to 90 days and presented to QAPI for compliance. The QAPI committee will review to determine. QAPI will continue to review this Quarterly at a minimum for two QAPI reviews, 90 days. Responsible for this is the Medical Records Designee/MRD to report after each transfer/discharge, Monthly at QA	

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 _____	11/17/2022

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 5	F 623	and quarterly at QAPI for two consecutive QAPI's, 90 days. Administrator, QA, QAPI to over see this report.	
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- §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:	F 625		12/11/22

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 _____	11/17/2022

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 6 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure elders or elders' representatives received a written notice of the bed-hold policy for 1 of 1 sample elders (#26) reviewed for hospitalization. The findings were: 1. Review of a progress note dated 11/9/22 and timed 9:15 AM showed elder #26 was a direct admit to the hospital for placement of a PICC (peripherally inserted central catheter) line and was scheduled for surgical debridement of a left leg post-surgical wound. The following concerns were identified: a. Review of the medical record showed no evidence a written bed-hold policy was provided to the elder, or elder's representative at the time of transfer. b. Interview with the DON on 11/17/22 at 10:31 AM revealed the elder went to a physician visit and returned to the facility for 1 night. After returning to the facility, the physician notified the facility the elder needed to be sent to the hospital for admission. The elder was sent to the hospital the day after the physician visit. c. Interview with LPN #1 on 11/17/22 at 11:30 AM confirmed she was the nurse that prepared documents for the elder at the time of the transfer. Further interview revealed she did not provide a written bed-hold policy to the elder or the elder's representative at the time of the elder's transfer. 2. Review of the policy titled "Holding Bed Space" provided by the facility 11/17/22 showed "...2. When emergency transfers are necessary, GHLS will provide the Elder or representative (sponsor) with information concerning our bed-hold policy within twenty four (24) to forty-eight (48) hours of	F 625	Tag 0625-483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon transfer 1. Elder 26, The Clinical Support Team, License Nurse did not document notification of Bed Hold. Director of Nursing and Administrator met with Responsible party and explained the Bed hold policy. Documentation did not occur. And audit occured to review if any other elders were affected by this policy. Results presented to QA Team. No deficiencies were noted at this time. 2. All Elders and #26 have the potential to be affected by this issue. Social Service Coordinator will follow up with Responsible party after a leave occurs with an Elder as a reminder of Bed Hold Status and document in the progress notes of notification. Medical Records Designee will audit EHR charts for Licensed documentation, and 24 hour audit and follow up with Responsible party on Bed Hold policy and documentation. MRD will follow up with Financial Officer if there are financial questions on behalf of Responsible party. Documentation of call to RP by Social Service Coordinator shall be reflected in Progress notes. In the absence of the Social Service Coordinator, the Financial Officer shall conduct audits, notification to families should the License nurse not notify the Responsible party. Audits shall be reported to Quality Assurance and to QAPI committee for review of effectiveness and so that no	

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 _____	11/17/2022

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 7 such transfer..."	F 625	other Elders are affected by this deficiency. This is continue for two quarterly QAPI's reviews for it's effectiveness and completeness. 3. Training occurred for all Licensed staff by Infection Preventionist Coordinator, LPN and Administration staff on policy on Bed Hold Agreement. Licensed staff was trained on what documentation and verbiage to use with Responsible Parties. In addition, how to refer financial questions the Financial officer during business office hours. All Administration, Licensed staff have been educated of bed hold policy to Responsible party upon leaving GHLS to acute setting or a therapeutic leave. 4. Audits shall occur after each discharge and reported immediately to Director of Nursing and then to Administration. Results of audits shall be reported to Quality Assurance and to QAPI committee for review of effectiveness and so that no other Elders are affected by this deficiency. This is continue for two quarterly QAPI's reviews for it's effectiveness and completeness. 5. The QA team shall review monthly the results of audit for it's effectivness and give suggestions if a PIP shall be instilled for it's effectiveness. The education completed on 12/9/22. And will be on-going at orientation and/or on-boarding.	

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 _____	11/17/2022

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 8	F 625	Compliance for this Tag is 12/10/22	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656		12/8/22

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 _____	11/17/2022

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 9 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure a care plan was comprehensive regarding pressure ulcer prevention for 1 of 6 sample elders (#3) reviewed regarding pressure ulcer care. The findings were: Review of the 10/18/22 quarterly MDS assessment showed the elder was admitted to the facility on 7/26/16. The elder had diagnoses which included Parkinson's disease, and s/he had no pressure ulcers identified. Further review showed the elder required extensive assistance of two staff members for transfers, and s/he was rarely understood and could not answer any of the cognition questions. Observation on 11/15/22 at 11:49 AM showed the elder was in bed with heel protectors applied to both feet. Review of the facility Roster/Sample Matrix showed the elder had a pressure ulcer. The following concerns were identified: a. Review of the 4/14/22 and 10/6/22 Braden Scale for Predicting Pressure Ulcer Risk showed the elder's score was 11, or at a high risk of developing a pressure ulcer. b. Observation on 11/16/22 at 10:31 AM showed the elder had a sacral area dressing,	F 656	Tag 0656-483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan 1. Elder #3, and All elders could be affected. Clinical Support Team, Infection Preventionist did body checks of all elders for identification of any skin concerns. Consultation with Wound consultant for any products necessary or equipment. Updated Care plans and documentation subsequently was made in any EHR system for the elderly. All Elders at risk as identified for Pressure ulcers were reviewed and if needed updated in Care plan process and if consultation with Wound consultant. 2. An Audit by Medical Records Designee on each Elders chart occurred to ensure the following: Verify the Braden scale are completed and up to date. To be done Quarterly and as needed per Change of condition (COC). EHR system will be contacted to change frequency of Assesment to be in the electronic system. Rights to do this has been requested on 12/5/22 from	

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 _____	11/17/2022

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 10 which was removed by LPN #2. The area appeared to be open and whitish in the center, and the area was small. Interview with LPN #2 at that time confirmed the wound was a pressure ulcer, and she stated the wound was not stageable. c. Interview on 11/16/22 at 4:02 PM with the consultant physical therapist for wound care confirmed the elder's wound was a pressure ulcer, which she stated was a stage III, particularly in the middle of the wound. The consultant stated it was imperative that implementation of an adequate plan for both prevention and treatment include repositioning and offloading the elder routinely. d. Review of a 9/27/22 skin/wound note timed 3:45 AM showed the elder received a bed bath and staff discovered a "left gluteal cleft skin open area suspected as an ulcer". e. Review of the care plan for the elder showed the following problem initiated on 10/27/22 (17 days after identification of a pressure ulcer on the elder) , "Problem: I have a moisture associated injury to my coccyx r/t [related to] incontinence. Goal: My skin injury will be healed by review date...target date 1/17/23. Interventions: Encourage/educate me and/or my representative to shift my weight frequently, about proper skin care to prevent skin breakdown, the importance of keeping skin clean and moisturized, and nutrition. If I refuse treatment, confer with me, the IDT and my family/caregiver to determine why and try alternative methods to gain compliance. Document alternative methods. Nursing to conduct skin check per protocol for any breakdown. Shahbaz to report skin concerns to nursing with cares and observations. Keep my skin clean and dry. Use barrier creams per protocol and as ordered. Nursing to educate me	F 656	PCC. Identify Elders at risk for pressure injury. Identifiers are weight loss, COC, altered Mental status, initial admission, medications that cause nausea or side effects. This will be conducted by IDT review of any triggers.Ensure the problem at risk elderly individual for developing a pressure injury is present on their care plan the bring to IDT for update and plan of care. Notify physician, wound consultant for updated care plan intervention if any. Input the specific Braden score into thier care plan if they are at risk fo devleoping pressure ulcers and update this score quarterly as Bradens are due. Ensure the indiviualized intervention of 'turn/repositon every 2 hours' is present on the care plan along with any other idividualized intervention that are needed. With any change of Condition, new wound and quarterly, a Braden assessment will be performed by either the MDS nurse or Wound nurse or staff nurse. The outcome will be directed to the Wound specialist and physician notified if the outcome demonstrated a need for COC, change in direction of care. 3. The wound policy was updated by Infection Preventionist & Quality Assurance team to include the New Braden to be performed when a new wound is identified or a significant change of condition is noted. Update the wound policy that the MDS is	

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 _____	11/17/2022

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 11 and/or my family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Position me off of the affected areas. Change my position per my positioning schedule and as needed for comfort and pressure reducing measures. Weekly and daily assessment/treatment of wound status to be conducted by nursing per policy and protocol." f. Interview with the administrator, DON, and IP on 11/17/22 at 11:20 AM revealed the care plan for the elder should take into account the Braden assessment regarding pressure ulcer risk, and the plan should address measurable preventative measures to reduce pressure ulcers before they occur, which would include staff assistance for repositioning.	F 656	to be notified of new wounds so that care plan can be appropriately and timely updated with needed interventions, and/or to perform a new Braden and adjust care plan accordingly. Continue to perform Braden assessments quarterly and MDS will update the score and individualized interventions as the scare indicated, including adding individualized Tasks for Shahbazim/CNA's. that will perform and document. Training of Comprehensive care plans to the Licensed Staff were reviewed on 12/8/22 by MDS Director, RN. 4. Infection Preventionist, Wound License Nurse will report at IDT and QA outcomes of Change of Conditions. The IDT will review the chart and elders needs including dietary, activities, Social Service Coordinator for identification of changes to care. MRD will audit 24 hour after admission, coc, and report to Director of Nursing, MDS and wound nurse the finding. A written report will be presented to QA, QAPI each month for two consecutive quarters for the QAPI to review it progress so that no Elder is affected by this deficiency. 5. QM will monitor and audit monthly with MDS reporting measure taken to ensure compliance each meeting of QA and	

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 _____	11/17/2022

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 12	F 656	QAPI. These notes may be brought up at Morning Meeting currently Monday and Wednesday. MDS Director, RN, may create a PIP on Comprehensive Care Plan if QAPI feels the is a need for further follow up.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure appropriate safety devices were utilized during transfers for 2 of 4 sample elders (#7, #13) reviewed for accident hazards. The findings were: 1. Review of the quarterly MDS assessment dated 8/11/22 showed elder #13 had a BIMS score of 2 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and hemiplegia or hemiparesis. Further review showed the elder required total physical assistance of 2 or more people for transfers and extensive physical assistance of 2 or more people for bed mobility. The following concerns were identified: a. Observation on 11/16/22 at 10:24 AM	F 689	Tag 0689- 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices 1. Elder #7 & #13, The Guide, a 9 year CNA and RN, Director of Nursing checked on Elders to ensure their body muscles, joints or skin were not inquired. A second visit occurred by Administrator, elders voiced no concerns. Wound Nurse, Infection Preventionist reported there is no skin abrasion. Elder #7, #13 and all elders could be affected by this practice. Gait belts were attained for all elders. It was ensured that all Elders were provided with their own Gait Belts. A few extra were purchased and will be kept on	1/19/23

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 _____	11/17/2022

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 689	Continued From page 13 showed shahbaz #1 and shahbaz #2 attempted to reposition the elder in the wheelchair by standing on each side of the elder with each shahbaz placing an arm under the resident's arms and lifting. During the attempt, the resident said "no, no, no" and made a loud groaning noise when the shabazim lifted. Following the attempt shahbaz #1 said they did not move the elder and they asked shahbaz #3 to assist. During the second attempt, shahbaz #1 and shahbaz #2 each stood on each side of the resident and placed their arms under the resident's arms, and shahbaz #3 stood at the elder's feet and placed her arms under the elder's legs. The elder stated "no, no, no" and when the 3 shahbazim physically lifted the resident out of the chair, the elder made a loud groaning noise. After the repositioning, the elder verbalized s/he felt "better." b. Observation of a ball toss exercise on 11/16/22 at 11:19 AM showed the elder did not want to attempt to throw the ball and verbalized to shahbaz #1 his/her "shoulders hurt." c. Observation of a stretching exercise on 11/16/22 at 11:21 AM showed the elder attempted to move his/her arms from side to side and had limited range of motion. At that time shahbaz #1 told the elder "Oh, your shoulders are stiff." 2. Review of the quarterly MDS assessment dated 11/1/22 showed elder #7 had a BIMS score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included hemiplegia or hemiparesis, anxiety disorder, manic depression, and unspecified pain . Further review showed the elder required extensive physical assistance of 2 or more people for transfers and bed mobility. Review of the care plan showed the resident required extensive assistance of 2 staff for transfers. The following	F 689	hand should a New elder be admitted or one not be able to be located. Each elder will keep their gait belt in their room. All equipment has been tested by Maintenance Director, and equipment are all functional for Elders at time of survey. 2. Skin assessments were performed to ensure no injuries were noted. And Elders were checked for body mechanics during transfers. Observation of transfers will occur by Clinical Support Team and/or Guide periodically. 3. Training on Gait Belt usage was given on 12/8/22 to Shahbizm by Guide. Staff will be re-educated on 01/19/23 to identify mode of tranfer in the elders Kardex. In the Kardex in each elders chart will identify what form of mode of transfer is to be utilized. Staff, Shahbaz and License staff received training on determining, location of mode or method of transfer. This training included mechanical lift, gait belts. This training was provided by RN, MDS Director and Guide, CNA. Training to Licensed staff, by Infection Preventionist Coordinator, LPN and Shahabizm on when an Elder refuses a transfer what other approaches could be tried. For example: Educate elder, re-aproach, another Shahabizm, change time, get off subject, distraction, document times tried and risk were reviewed with elder or responsible party.	

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 _____	11/17/2022

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 689	Continued From page 14 concerns were identified: a. Observation on 11/14/22 at 4:39 PM showed LPN #1 and shahbaz #4 assisted the elder to stand from a recliner to a wheelchair. The LPN and shahbaz lowered the recliner's leg rest and, the staff members standing on each side of the resident, assisted the elder by placing an arm under the elder's arms and lifting the elder to a standing position. The staff members assisted the elder to pivot, then sit into a wheelchair. There was no gait belt used during the transfer. b. Interview with shahbaz #4 on 11/14/22 at 4:56 PM revealed staff "normally use a gait belt" for the transfer and for any transfer of elders without a mechanical lift; however, the facility just moved residents to the Founders cottage from the Watt cottage and some of their equipment was not available. 3. Interview with the DON on 11/17/22 at 11:55 AM revealed lifts were available to use for everyone. Further interview revealed it would not be appropriate to lift an elder under their arms. If the elder was unable to grab the staff member's hands, a device should be utilized for elder and staff's safety.	F 689	Pain assessment, medication for anxiety, discuss fears. License staff to document in notes their intervention. All equipment has been tested by Maintenance Director, and equipment are all functional for Elders at time of survey. 4.The mechanical audit will continue on a monthly and documented presented to QA and QAPI for two consecutive QAPI's. 5. Documentation of mechanical devices and training shall be presented to QA and QAPI for review for a minimum of two QAPI to assure it's effectiveness is present so no elders are affected by this deficient tag. QAPI shall recommend PIP if needed for further intervention. Education completed by 01/19/2023 Guide, Director of Nurse and/or Administrator to monitor this Deficient tag.	
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;	F 758		12/10/22

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 _____	11/17/2022

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 15 (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 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.	F 758		

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 _____	11/17/2022

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 16 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedure, the facility failed to ensure appropriate behavior monitoring and interventions were in place for 1 of 4 sample elders (#13) who received psychotropic medications. The findings were: 1. Review of the quarterly MDS assessment dated 8/11/22 showed elder #13 had a BIMS score of 2 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia and depression. Further review showed the elder had a depression score of 0 out of 27, which indicated minimal depression, and verbal behavior symptoms directed at others which occurred daily. Review of the physician orders showed the elder received escitalopram oxalate (antidepressant) 10 mg by mouth every day for depressive disorder and quetiapine fumerate (anti-psychotic) 25 mg bid (twice a day) by mouth for behavioral disorders associated with dementia. The following concerns were identified: a. Review of the "I use antidepressant medications r/t depression" care plan last revised on 5/12/22 showed interventions which included "monitor me for and report as needed any changes in mood or increase in depressive symptoms." Further review showed no evidence of resident specific target symptoms. b. Review of the "I use the antipsychotic medication r/t Behavior Management" care plan last revised on 8/3/22 showed interventions which included "Monitor/record occurrence of my target behavior symptoms include the identification of risks or contributing factors to my behavior, the desired outcomes, the use/effectiveness of any	F 758	Tag 0758-483.45(c)(3)(e)(1)-(5) Free from Unnecessary Psychotropic Meds/PRN Use 1. Elder #13 and all elders using psychotropic medications have the potential to be affected by this concern. Elder #13 and all elders on psychotropics target symptoms were reviewed by MDS, RN. Guidance given to Clinical support Team and to Shahbazm regarding triggers that may be contributing to behavior. Review of potential non-pharmacological interventions to attempt first before intitiating psychotripic order. 2. An audit of elders who are on psychotropic medications was performed for interventions and target symptoms. The findings will be presented at IDT and QA for disussion, educational and changes in behavior management. 3. Reviewing Policy on Antipsychotic Medication use, Education was performed with MDS, RN staff regarding the policy with discussion. This training was completed by the MDS Director, RN. This training was on: Target Behaviors and where to document Identification of risk or potential contributing factors. Elders individual desired outcomes. Non-pharmacological interventions and documentation	

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 _____	11/17/2022

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 non-pharmacological interventions, and potential adverse effects." Further review showed no evidence of resident specific target symptoms. c. Review of the MAR and TAR for September 2022, October 2022, and November 2022 showed the facility had monitoring in place for withdrawal symptoms related to the use of psychotropic medication; however, there was no evidence the facility was monitoring the elder for identified target symptoms specific to the use of each psychotropic medication. d. Interview with LPN #1, DON, and administrator on 11/17/22 at 11:55 AM revealed the elder had combativeness and anxiety; however, the facility had not identified specific target symptoms or non-pharmacological interventions for the use of the psychotropic medications. 2. Review of the policy titled "Antipsychotic Medication Use Policy" last reviewed 5/23/22 showed "...1. Elders will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective...4. Nursing staff will document in detail an individual's target symptom(s)..."	F 758	Education completed on 12/10/2022 Pharmacy report to be reviewed Monthly and recommendations sent to Physician for alternate care direction. 4. Director of Nurse and Clinical Support Team to review and monitor at IDT elders diagnosis, medication usage, behavior documentation and non-medication or medications effectiveness. It will be documented in progress notes. 5. Director of Nurses to report to QA and QAPI committee out come of data and make recommendations for positive outcome for the elders so that over utilization or effectiveness of antipsychotic medication is documented and reviewed. Consultation with the Physician and pharmacist will be included in these reviews. Medical Records shall review chart for psychotropic medication documentation in MAR. In addition, training shall be reviewed at QA. The QAPI team will look at pharmacy report, Medical Records audits and determine if training has been effective. Director of Nursing and/or Administrator to monitor this at QA and QAPI for 90 days for systemic concerns.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		12/9/22

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 _____	11/17/2022

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 865	Continued From page 18 Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the	F 865		

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 _____	11/17/2022

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 865	Continued From page 19	F 865		

facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and 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 _____	11/17/2022

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 865	Continued From page 20 provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on the review of the 10/28/21 recertification 2567, QAPI meeting minutes review and staff interview, the facility failed to ensure the QAPI program adequately addressed identified infection control concerns in 3 of 3 cottages (Founders, Whitney, Scott) where elders resided. The findings were: Review of the 10/28/21 recertification 2567 showed the facility was cited at F-880 for staff not wearing protective PPE as required in 2 of 4 cottages. Review of the 5/18/22, 6/9/22, 7/25/22, 8/15/22, and 9/21/22 QAPI meeting minutes showed the facility had a QAPI program with the required staff members, and issues were identified and addressed; however, the facility	F 865	Tag 0865-483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Program/Plan 1. All elders have the potential to pose a risk toward. Administrator met with QA team to review minutes to include identified infection control concerns. 2. Policy and Procedure to include a review of all minutes and data for compliance for the QAPI policy for safety of the Elders. 3. Green House Living for Sheridan has a QAPI policy in place and has been amended to include the following:	

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 _____	11/17/2022

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 865	Continued From page 21 failed to address infection control concerns, which included staff wearing PPE as required in 3 of 3 cottages (Founders, Whitney, Scott) where elders resided, and that remained an issue. Interview on 11/17/22 at 1:55 PM with the administrator confirmed the facility had not adequately addressed staff non-compliance with utilization of PPE when appropriate.	F 865	The QAPI program will adequately document minutes to identify problems. It will review identified problems at each meetings if concerns need further interventions until resolved in writing. All staff have been educated by Infection Preventionist Coordinator, LPN. Managers have been educated by Administrator and understand the QAPI policy. The QA Committee has reviewed the Policy and approved the policy changes. 4. Managers are educated to observe during their walk through on PPE utilization and to document findings in writing to the Director of Nursing and/or the Administrator. 5. QA committee shall review Managers observations on a monthly basis and report to QAPI Team. Education was completed by 12/9/22. Policy was amended on 12/8/22. IPC and HR Coordinator to report to QA and QAPI for an three consecutive quarters on Exemption numbers both elders and employee's. Compliance completed on 12/9/22	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		12/9/22

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 _____	11/17/2022

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		

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;

§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

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 _____	11/17/2022

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 23 (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. §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 observation, staff interview, review of the Centers for Disease Control (CDC) guidance, review of the CDC community transmission rates, and review of the policy and procedure, the facility failed to ensure staff used appropriate PPE in 3 of 3 cottages (Founders, Whitney, Scott) while in elder care areas. In addition, the facility failed to ensure appropriate infection control techniques were implemented to prevent cross contamination during 1 random observation of catheter care which affected elder #4. The findings were: Related to PPE use:	F 880	Tag 0880-483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control 1. Elder #4 was checked by Infection Preventionist, LPN for any sign and symptoms of infection. There was no indicators that Elder #4 experienced a negative outcome from LPN #3. Immediate education was provided to LPN. All elders have the potential to be affected. 2. All Elders with catheter care, ostomy care, hygiene care were observed by	

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 _____	11/17/2022

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 24 1. Observation in Founders cottage on 11/14/22 at 4:39 PM showed LPN #1 and household assistant #1 were assisting in care areas and no face masks or other personal protective equipment was worn. 2. Observation in Whitney cottage on 11/15/22 at 10:52 AM showed shahbaz #1 and household assistant #2, were assisting in care areas and no face masks or other personal protective equipment was worn. 3. Observation in Whitney cottage on 11/16/22 at 10:07 AM showed shahbaz #1, household assistant #2, shahbaz #3, and shahbaz #2 were assisting in care areas and no face masks or other personal protective equipment was worn. 4. Interview with LPN #1 11/17/22 at 12:30 PM revealed she was the infection preventionist and she had been checking "infection rates" when she got to the facility; however, she did not check the community transmission rates. She confirmed all staff should wear a face mask when the rates were high and when the facility was in outbreak status. 5. Review of the CDC's "COVID-19 Integrated County View" showed the community transmission rate for the county in which the facility was located increased to high on 11/10/22 and remained high on 11/14, 11/15, and 11/16. 6. Review of the CDC's "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" last revised on 9/23/22 showed "...Community	F 880	Infection Preventionist for infection and proper utilization of PPE during care. Any change in Condition of catheter or ostomy related elders are to be brought immediatley to the IPC, LPN attention and IDT. 3. Infection Preventionist, LPN educated Licensed staff and Shahbaz on proper infection control with PPE equipment when doing elder care. Policy was reviewed with Licensed staff. And was reviewed at QA on 12/8/22 for any addendums necessary. QA did not fine a need to change Policy however, continuous education is necessary to ensure that this deficient practice does not occur with other Elders. Education was completed on 12/9/22 with all licensed staff. Performed by Infection Preventionist Coordinator,LPN. Training shall continue until two consecutive QA and QAPI or when the committee see that this practice is being adhered to from observation through documentation and presentation to QAPI. 4. Clinical Support team, Guide/CNA, IPC shall all work in conjunction to periodically train, educate and observe and document finding of direct care staff for proper PPE utilization and presented to the QAPI. Training shall be on going on a quarterly basis. These findings shall be presented to Director of Nursing and/or Infection Preventionist Coordinator, LPN. 5. QA and QAPI will gather information on	

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 _____	11/17/2022

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 25 Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system and to better protect the individuals seeking care in these settings. The Community Transmission metric is different from the COVID-19 Community Level metric used for non-healthcare settings. Community Transmission refers to measures of the presence and spread of SARS-CoV-2. COVID-19 Community Levels place an emphasis on measures of the impact of COVID-19 in terms of hospitalizations and healthcare system strain, while accounting for transmission in the community...When SARS-CoV-2 Community Transmission levels are high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter patients. HCP [health care personnel] could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and Community Levels are not also high. When Community Levels are high, source control is recommended for everyone. When SARS-CoV-2 Community Transmission levels are not high, healthcare facilities could choose not to require universal source control. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who: Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days	F 880	training and any cross contaminates that may have occurred. IPC shall note any catheter care training necessary to both Licensed staff and Shahabizm. The Infection Preventionist Coordinator, LPN will develop in conjunction with QIO (Quality Improvement Organization) and improved Infection control surveillance program. In addition, The Director of Nurses or MDS Director will continue to develop and present the infection rates at Green House Living for Sheridan. Areas that are noted to be a PPE or infection control concern, a PIP through QA could be developed for education and compliance. This will be reviewed with data and educational documentation at QA and QAPI for a period of two consecutive. IPC shall review all data with the Director of Nurses and/or MDS Director for any changes need to education or policy. These changes shall be presented to QA for identification if a PIP should be initiated. This is in compliance as of 12/9/22	

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 _____	11/17/2022

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 26 after their exposure; or Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; or Have otherwise had source control recommended by public health authorities..." Related to catheter care: 1. During a random observation on 11/16/22 at 4:26 PM, LPN #3 performed hand hygiene and donned gloves to assess and clean the urinary catheter of elder #4 in his/her bathroom. During the observation, after donning gloves but just prior to cleaning the catheter of elder #4 with alcohol wipes, LPN #3 touched her gloves to a support rail, the elder's wheelchair, and the elder's shoulder. Then, without changing gloves, she proceeded to clean the elder's catheter with alcohol wipes, and she held the catheter with the contaminated gloved hands. Interview at that time with LPN #3 confirmed she should have changed gloves and performed hand hygiene after touching contaminated surfaces. 2. Review of the Infection Control Policy last updated on 9/24/22 included the following, "...3. The IP will be responsible for implementing, monitoring, and evaluating the infection control program. Duties will include: a. Surveillance, including calculating infection rates, developing a plan of action to reduce identified problems, and compliance with process measures, such as hand hygiene use of PPE, and indwelling catheter care and maintenance..."	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881		12/10/22

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 _____	11/17/2022

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 881	Continued From page 27 §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure an effective antibiotic stewardship program was implemented to identify appropriate use of antibiotics for 2 of 3 sample elders (#1, #8) with prophylactic antibiotic orders. The findings were: 1. Review of the physician orders showed elder #1 had an order to receive ciprofloxacin hydrochloride (antibiotic) 500 MG by mouth as needed for Prophylaxis one hour prior to supra pubic catheter change once a month dated 8/14/22. The following concerns were identified: a. Interview with LPN #1 11/17/22 at 12:03 PM confirmed she was the infection preventionist and revealed she was not aware of a standard of practice to utilize antibiotics as was ordered for the elder. Further interview revealed she was not aware of a physician rationale for the medication usage. 2. Review of the physician orders showed elder #8 had a 1/20/22 order to receive cephalexin (antibiotic) 250 mg every other day for UTI [urinary tract infection] prophylaxis. The following concerns were identified:	F 881	Tag 0881-483.80(a)(3) Antibiotic Stewardship Program Infection Control Prevention and control program Antibiotic Stewarship program 1. All residents who are on antibiotic orders have the potential to be affected by this concern including elder #1 and #8. Elder #1 is receiving antibiotics prior to catheterization to prevent infection per Physicians order. Elder #8 Physician stated that elder had been hospitalized several times due to Sepsis of a Urinary tract system. And wanted Elder to remain on Prophylactic antibiotic. 2. Infection Preventionist Coordinator, LPN will quarterly review elders with history of UTI and catheters. IPC will identify existing UTI within the last quarter, anyone on a catheter or new catheter. 3.The Policy for Antibiotic Stewardship for Green House Living for Sheridan has been updated to include: Review of antibiotic therapy for treatment	

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 _____	11/17/2022

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 881	Continued From page 28 a. Review of the July 2022 pharmacy recommendation showed the pharmacist recommendation was to stop the cephalexin. The review showed the physician signed the form and declined to change the order. However, the physician failed to include a rationale to continue the order. 3. Interview with LPN #1 on 11/17/22 at 12:03 PM confirmed the facility did not have an antibiotic stewardship program in place to monitor and ensure appropriate use of antibiotics at the facility. 4. Review of the policy titled "Antibiotic Stewardship Policy" last reviewed on 6/6/22 showed "...2. Develop and maintain a system to monitor antibiotic use, which includes: a. Review antibiotics prescribed to residents upon their admission or transfer to the facility, in response to an acute illness by their PCP, and those prescribed during an outside evaluation by a practitioner who is not part of the facility's staff (e.g., emergency department provided, specialty provider). b. Periodically review a subset of antibiotic prescriptions for inclusion of dose, duration and indication, (or for length of therapy, documentation of an antibiotic time-out, appropriateness based on antibiotic use protocols and written documentation of clinical justification for antibiotic use that does not comply with the facility antibiotic use protocols). Periodically review rates of prescriptions for any antibiotics or conditions identified by the committee as being of special interest. c. At least annually, review antibiotic use data by the facility and by individual providers to determine if there is excessive use of specific antimicrobial agents. The assessment will measure antibiotic starts (antibiotic days of	F 881	of Urinary tract infection regarding checking the UA to confirm zero bacteria present. Daily evaluation measure to keep Elders from discomfort during the UA result pending. Ensure the Physician adequately documents continued use of Antibiotics by documenting a reason, diagnosis and/or a stop date of from start and re-evaluate antibiotic use after 14 days if still on. If the Physician does not agree with recommendations by the Pharmacist, the physician will document the benefits verses risk of the usage of the medication. Education will be on-going regarding measure to use for high risk elders of UTI's. Elders who have a history of UTI's. This education will involved both License staff and Shahabizm. It shall be on-going and quarterly and presented to the QA committee for it's effectiveness and reviewed. Catheter care will also be presented to Shahabizm in training by the Infection Preventionist Coordinator, LPN. Education on MdGeer Criteria will be included to Licensed staff, by Infection Preventionist Coordinator, LPN. 4. Infection Preventionist Coordinator shall review and monitor these educations and data for it's effectiveness and present it to QA and QAPI. This shall be on going for a a minimum of three QAPI or until QAPI	

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 _____	11/17/2022

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 881	Continued From page 29 therapy, defined daily doses of antibiotics) per 1000 resident days of care (and/or length of therapy). If excessive use or other conditions are identified, the facility will take actions to address these problems...4. Provide education on antibiotic stewardship, which will: a. At least annually, provide education on antibiotic stewardship and on the facility's antibiotic use protocols to prescribing practitioners and nursing staff..."	F 881	feels it has been effective in reducing Antibiotic usage. 5. Pharmacy monthly report also to be reviewed at QA and QAPI for effective appropriate reduction of antibiotic on a monthly basis. QAPI team will suggest a PIP if this concern continues. Education completed by 12/10/22	
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.	F 888		12/10/22

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 _____	11/17/2022

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 888	Continued From page 30 §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely	F 888		

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 _____	11/17/2022

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 888	Continued From page 31	F 888		

documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to,

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 _____	11/17/2022

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 888	Continued From page 32 individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview, staff vaccine documentation review, and policy and procedure review, the facility failed to ensure a procedure was in place to monitor for compliance regarding additional precautionary measures intended to prevent the transmission and spread of COVID-19 for those staff who were not fully vaccinated. There were 19 of 50 employees and 2 of 7 contracted employees who were granted exemptions. The findings were: Review of the 4/7/2022 policy and procedure titled, "COVID-19 Vaccination Mandate Requirement Policy" showed the facility had a policy and procedure to address COVID-19 vaccination status for staff. The following concerns were identified: a. Review of the 4/7/2022 policy and procedure regarding staff vaccination and exemptions for COVID-19 showed the facility had	F 888	Tab 0888-483.80(i)(1)-(3)(i)-9(x) Covid-19 Vaccination of Facility Staff An audit was performed on all Staff and HCW,consultants who do are not 'up to date' with primary series by Human Resource Coordinator. Results introduced to Infection Preventionist. And a Booster clinic will be scheduled before end of year for those who are outside of their 2 month period for their Booster. And those who are not Covid -19 Vaccinate are offered a vaccination to be considered eligible for a Booster after the second dose of Primary Series and within their two month window. Those HCW, Consultants who are not Primary Vaccinated shall wear a surgical mask while in the presence of an Elder or staff.	

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 _____	11/17/2022

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 888	Continued From page 33 a process in place for staff to apply for medical and religious exemptions. Further review showed the following, "...E. GHLS will develop and implement procedures to:...3. Request and document Exemption Applications and their outcomes, 4. Mitigate the transmission of COVID-19 for all employees who are not fully vaccinated...a. Any employee or volunteer who is not fully vaccinated must continue to wear a mask until fully vaccinated." Further review showed the facility failed to develop procedures to monitor staff for compliance with this requirement. b. Interview with the administrator, DON, and IP on 11/17/22 at 12:32 PM confirmed the facility failed to ensure a procedure was in place to monitor staff who were not up-to-date with COVID-19 vaccinations for compliance with the policy requirement for mandatory wearing of masks.	F 888	This clinic shall occur prior to the end of the year, December 31, 2022. IPC and her designee will arrange for this to include HCW consultants, Elders and employee's. This shall be monitored by Human Resoureces on a monthly bases and the outcome provided to the Infection Preventionist Coordinator, Adminsitrator and Director of Nurses. A consent form will be provided to all eligible individuals. Responsible parties shall recieve notification of invite for their elderly to receive a Booster. The updated data shall be primarily kept up to date by the Human Resource Coordinator and Infection Preventionist Coordinator shall have the ability to review it monthly for compliance. The IDT shall review covid-19 status of each elderly at their review time. This process shall be evaluated at QA and QAPI. Human Resource Coordinator and/or Infection Preventionist shall report data. This is in compliance on 12/10/22. Clinic to occur before end of year for those outside of their two month window of a Booster. And Vaccination for Primary will be offer at clinic for those who are exempted.	