

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                      |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                            |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                                                                                                                                |                            |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETION<br>DATE |                                                      |
| F 000                                                               | INITIAL COMMENTS<br><br>A complaint survey was conducted by Healthcare<br>Licensing and Surveys from 3/19/24 to 3/20/24.<br>The survey was prompted by complaint intakes<br>WY00003792, WY00003798, WY00003805,<br>WY00003811, WY00003814, WY00003818,<br>WY00003819, and WY00003827.<br><br>The following common abbreviations are used<br>throughout this document:<br><br>BIMS: Brief Interview for Mental Status<br>CEO: Chief Executive Officer<br>CNA: Certified Nursing Assistant<br>DON: Director of Nursing<br>LPN: Licensed Practical Nurse<br>MDS: Minimum Data Set<br>NHA: Nursing Home Administrator<br>RN: Registered Nurse<br>Shahbaz: Certified Nursing Assistant<br>SW: Social Worker<br><br>Less commonly used abbreviations will be<br>annotated in each deficiency.<br><br>F 695 Respiratory/Tracheostomy Care and Suctioning<br>SS=D CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including<br>tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who<br>needs respiratory care, including tracheostomy<br>care and tracheal suctioning, is provided such<br>care, consistent with professional standards of<br>practice, the comprehensive person-centered<br>care plan, the residents' goals and preferences,<br>and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced<br>by: | F 000                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                                                      |
| F 695<br>SS=D                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 695                                                               | F695 Respiratory/Tracheostomy Care and<br>Suctioning.<br><br>It is the policy of this facility to ensure the<br>highest quality of care for all of our Elders.<br>Consistent with this practice, the following<br>has been done as there is the potential for all<br>residents to be affected.<br><br>1. Social service called current Vendor to<br>request Wisp mask to meet Elder #3's needs<br>to 04/09/2024. If unable to receive requested |                            |                                                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

*E. Maguire*

4-12-24

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.

*DOC accepted. spoke to Elizabeth Maguire on 4/12/24 @ 1:58 PM.*

*DOC 5/1/24*

*Janice*

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                      |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | (X5)<br>COMPLETION<br>DATE                           |
| F 695                                                               | <p>Continued From page 1</p> <p>Based on medical record review, and elder and staff interview, the facility failed to have a system in place to ensure respiratory care was provided consistent with the elder's goals and preferences for 1 of 1 elder reviewed (#3) for respiratory care. The findings were:</p> <p>1. Review of the 1/24/24 quarterly MDS assessment showed elder #3 had a BIMS score of 15 out of 15 (cognitively intact) and had a diagnosis which included an unspecified pulmonary disease such as asthma, chronic obstructive pulmonary disease, or chronic lung disease. The following concerns were identified:</p> <p>a. Interview on 3/19/24 at 8:21 AM with the elder revealed s/he had been having problems with his/her CPAP (continuous positive airway pressure) mask for "approximately 3 months". The elder stated s/he had spoken with the former DON and nothing was done so s/he called the respiratory service company in Casper and was informed the DON had to make the inquiry. The elder stated the SW recently brought him/her a grievance form and s/he was going to submit it "today".</p> <p>b. Review of a communication note, dated 2/26/24, showed "LATE ENTRY...Elder had some concerns about [his/her] CPAP mask not fitting properly and causing [his/her] eyes to become red, dry, and irritated. Elder was frustrated that the concern was not being addressed. SW advised Elder to reach out to regional ombudsman if she felt she was not (sic) being heard. Elder also asked to call the CPAP POC. SW obtained the CPAP number from DON and shared it with Elder. Elder called and was told [s/he] can have a consult with a CPAP representative but [Green House] has to set it up. SW informed DON."</p> | F 695                                                               | <p>mask from current Vendor by 04/30/2024, Elder #3 will change vendors for her respiratory services.</p> <p>2. MDS Coordinator will perform an audit to identify all Elders who currently use respiratory equipment. Social Services will perform a facility wide rounding for all Elders that require respiratory supplies to identify needs/issues weekly x one month and then monthly x 3 months. Care Conferences held by Social Services will include a report on Elder's respiratory equipment/supplies. Any identified issues will be reported to the DON.</p> <p>3. Social services will report to QAPI findings regarding respiratory equipment from all audits and care conferences monthly x 3 months.</p> <p>4. Data for the audits will be presented to the Facilities/QAPI meeting monthly x 3 months. The DON and/or Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on: 05/04/2024</p> |  |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                      |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | (X5)<br>COMPLETION<br>DATE                           |
| F 695                                                               | Continued From page 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | F 695                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                      |
| F 725<br>SS=F                                                       | <p>2. Interview with the current DON on 3/20/24 at 11:47 AM revealed the CPAP representative had been called on 3/19/24. The former DON had recently resigned and was unavailable.</p> <p>Sufficient Nursing Staff<br/>CFR(s): 483.35(a)(1)(2)</p> <p><b>\$483.35(a) Sufficient Staff.</b><br/>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at \$483.70(e).</p> <p><b>\$483.35(a)(1)</b> The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br/>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br/>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p><b>\$483.35(a)(2)</b> Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, review of medical</p> | F 725                                                               | <p>F725 Sufficient Nursing Staff</p> <p>It is the policy of this facility to ensure the highest quality of care for all of our Elders. Consistent with this practice, the following has been done because there is the potential for all residents to be affected.</p> <p>1. The DON and/or Administrator will review weekly staffing, acuity and ratios prior to the upcoming week to ensure sufficient staffing is in place. DON and/or the Guide will review with staff to ensure the common areas are frequently monitored. With an increased focus for Elders #1, #2, #5.</p> <p>2. A communication binder has been implemented in each house to include any concerns or changes in acuity of Elders such as potential wandering. DON to review daily staffing concerns and make appropriate adjustments accordingly. MDSC to audit documentation weekly x 3 months and ongoing.</p> <p>3. Staff training on the Vigil Call System upgrades. Audit of the alarm sensors to be done weekly by the facilities manager x 3 months and then monthly x 3 months.</p> |  |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |                                                                                                                                                                                                                                                      |                            |                                                      |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                 |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                     |                            |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                             | (X5)<br>COMPLETION<br>DATE |                                                      |
| F 725                                                               | Continued From page 3<br>records, staff job descriptions, facility incident reports, the payroll report, and the daily nursing staff postings, and elder and staff interview, the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure elder safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of the elders. The census was 38. The findings were:<br><br>Review of the "Shahbaz Job Description" showed the Shahbaz were responsible for the following:<br>a. Recognize and respond to the needs of Elders and assure their safety at-all-times.<br>b. Report changes in the Elder's condition to the RN's per "change in condition" protocols.<br>c. Promptly observe, report and provide skin care and alert the presence of pressure areas to prevent decubitus as according to policy.<br>d. Maintain occupied and unoccupied beds, to include changing bed linens, when necessary.<br>e. Assist moving, positioning and transporting Elders into/from beds, chairs, bathtubs, wheelchairs, lifts, etc.<br>f. Assist elders with personal care functions, including: bathing, dressing, grooming, dental and mouth care, hair and nail care, bowel and/or bladder care, and as-needed personal hygiene care.<br>g. Assure that call notifications by the Elders are answered promptly and professionally.<br>h. Assist in performing restorative and rehabilitative procedures as outlined by care plans.<br>i. Obtain and record vital signs, such as temperature, pulse, respirations, weight, height, anatomical dimension and circumference, etc.<br>j. Assist with the application of slings, elastic bandages, binders, etc., as directed. | F 725                                                               | 4. Data for the audits will be presented to the Facilities/QAPI meeting monthly x 3 months. The DON and/or Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on: | 05/04/2024                 |                                                      |



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |                                                                                                                          |  |                                                      |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                         |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                           |
| F 725                                                               | <p>Continued From page 4</p> <p>k. Facilitate and/or assist Elder daily range-of-motion exercises, as needed.</p> <p>l. Follow safety precautions to observe, monitor, intervene or report any unsafe conditions.</p> <p>m. Prepare and serve meals; kitchen and dining room clean-up after meals; provide snacks as requested consistent with the posted menu and stated preferences of the Elder.</p> <p>n. Launder Elder's clothing, linen and other articles, as needed.</p> <p>o. Perform routine housekeeping duties including cleaning Elder living areas and environment.</p> <p>p. Perform other clinical support related duties, as requested.</p> <p>Related to Watt Cottage (Census = 7):</p> <p>1. Review of the 1/11/24 admission MDS assessment showed elder #1 had a diagnosis of non-Alzheimer's dementia, a BIMS score of 4 out of 15 (indicating severe cognitive impairment), and was independent with bed mobility, transfers, and had the ability to walk at least 150 feet. Review of the resident's care plan, dated 1/28/24, showed "I may wander or try to leave my cottage r/t History of attempts to leave facility unattended". The following concerns were identified:</p> <p>a. Review of a facility incident report, dated 2/3/24 and timed 9:20 AM, showed "Shabaz reported to nurse that they found Elder outside the cottage trying to leave campus..."</p> <p>b. Review of a facility incident report, dated 2/25/24 and timed 10:40 PM, showed "...CNA called RN to come outside right away as [the elder] was trying to escape the compound &amp; unable to redirect [elder]. Four staff showed up in</p> | F 725                                                               |                                                                                                                          |  |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                          |                            |                                                                    |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>535054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE</b><br><b>SHERIDAN, WY 82801</b>                           |                            |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                    |
| F 725                                                                      | <p>Continued From page 5</p> <p>front of the Watt building to try &amp; get [the elder] to return...very angry and confused. [11:30 PM]-[the elder] managed to slip out the front door with soap dispenser..."</p> <p>c. Review of a general progress note, dated 3/3/24 and timed 7:15 PM showed the Elder was in the common room watching television and spoke with the RN about "walking tonight to pick up a gas can for tomorrow"... (only 1 CNA present in house &amp; giving a shower to another resident.) RN stayed within house to watch [the elder] closely with [his/her] past history of elopement till CNA was finished giving a shower. Observed [the elder] walking around &amp; looking into the kitchen but also walking over to the exit doors. [The elder] asked nurse "about the locks on the doors." On 3/1, back door found open by another resident &amp; very sure it was [the elder]..."</p> <p>d. Review of an incident report, dated 3/10/24 showed "Shab haz called this nurse to ask for help with Elder after elder struck shab haz in the chest. Before nurse could arrive the shab haz called again informing that the Elder had picked up a broom and was swinging it. The shab haz got hit by the broom...The shab haz was able to regain the broom from the elder and then called the Elder's daughter to calm the Elder down. This was effective." Immediate action taken showed "This nurse went to the house the elder is staying in and sat with him/her ([the elder] was calm by this time [9 PM]). The elder's daughter arrived at 9:30 PM..."</p> <p>e. Review of a "Communication" note dated 3/11/24 and timed 4:21 PM showed "...SW also informed Elders daughter we will be sure to not schedule male Shahbaz in the cottage as it triggers Elder. SW clarified that there might be instances where a male might need to work in Watt due to staffing shortages."</p> | F 725                                                                      |                                                                                                                          |                            |                                                                    |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                          |  |                                                                        |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>535054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE</b><br><b>SHERIDAN, WY 82801</b>                           |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 725                                                                      | <p>Continued From page 6</p> <p>f. Review of a General Progress Note dated 3/17/24 and timed 3:58 AM showed "The elder continues to roam throughout the facility and excited (sic) the facility twice between the hours of 2000 (8 PM) and 2100 (9 PM)."</p> <p>g. Review of a General Progress Note, dated 3/18/24 and timed 12:32 AM showed "This elder continues to wander throughout the unit. [The elder] becomes frustrated and attempts to break the sliding doors into the kitchen area and goes through any closed door. [The elder] has gone outside into the parking lot and into the fenced in area in the back..."</p> <p>h. Observation on 3/19/24 at 11:18 AM showed the elder was sitting in the common room of Watt cottage with no staff in the vicinity. The elder was observed to ambulate independently.</p> <p>i. Review of the daily nurse postings showed on 2/3/24 the census was 3 with 2 CNAs and 1 nurse scheduled during the day shift; on 2/25/24 the census was 5 with 1 CNA and .5 nurse scheduled on the night shift; on 3/3/24 the census was 7 with 1 CNA and .5 nurse scheduled on the night shift; and on 3/17/24 the census was 7 with 1 CNA and .5 nurse scheduled on the night shift.</p> <p>j. Review of the Vigil call history report showed on 2/25/24 at 9:47 PM the elder departed his/her room at 9:48 PM, the door alarm at the lobby entrance triggered and was canceled at 9:52 PM; and at 9:52 PM an exit door alarm was triggered and was canceled at 11:08 PM.</p> <p>k. Interview with on 3/19/24 at 10:19 AM with elder #4 revealed that elder #1 had behaviors and attempted to exit the cottage. Elder #4 stated often times the staff were not readily available and the other elders in the cottage felt like it was their "duty" to keep the elder #1 from leaving the cottage.</p> <p>l. Interview with the DON on 3/20/24 at 11:47</p> | F 725                                                                      |                                                                                                                          |  |                                                                        |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                          |                            |                                                                        |
|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>535054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE</b><br><b>SHERIDAN, WY 82801</b>                           |                            |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                                        |
| F 725                                                                      | <p>Continued From page 7</p> <p>AM revealed the "Vigil" call system was launched at the beginning of March 2024 and the elder was going to be the first to be outfitted with the pendant which would monitor the elder's whereabouts. The DON was unsure how to interpret the Vigil call history reports as they were still learning the system.</p> <p>Related to Whitney Cottage (Census = 10):</p> <p>1. Review of the 12/30/23 quarterly MDS assessment for elder #5 showed the elder had a BIMS score of 6 out of 15 (indicating severe cognitive impairment) and wandered 1 to 3 days of the look-back period. Review of the elder's care plan, last revised on 8/29/23, showed the elder was independent with transfers and used a cane for walking. The following concerns were identified:</p> <p>a. Review of an incident report, dated 2/13/24 and timed 5:26 AM, showed "Elder exited facility and was brought back into Whitney cottage by day shift shahbaz who came early. [The elder] did not fall and had [his/her] jacket on... Employee exit alarm shows it had been ringing for 3 minutes."</p> <p>b. Review of an incident report, dated 3/2/24 and timed 9:40 PM, showed "Elder was found outside ambulating on east side of Founder's cottage at around [6:30 PM]" Further review showed the nurses that found the resident took him/her into Founder's cottage and then notified the shahbaz at Whitney. The note section of the incident report showed "somewhat tired after ambulating a great distance. [RN] states that [the elder] had walked past south side of cottage before turning northward on east side of cottage."</p> <p>c. Review of the daily staff posting from 2/1/24 through 3/19/24 (47 days) showed the cottage was staffed during the day with 3 CNAs</p> | F 725                                                                      |                                                                                                                          |                            |                                                                        |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     |                                                                                                                          |                            |                                                      |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                         |                            |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                      |
| F 725                                                               | <p>Continued From page 8</p> <p>on 15 days, 2 CNAs on 15 days, 5 CNAs on 1 day, and 16 days were left blank. During the night shift the cottage was staffed with 2 CNAs on 16 days, 3 CNAs on 2 days, 1 CNA on 1 day, and 28 days were left blank.</p> <p>Related to Scott Cottage (Census = 10):</p> <p>a. Observation on 3/19/24 at 11:18 AM showed 4 elders were sitting at the dining table in the common room in their wheelchairs. Activities assistant #1 and CNA #2 were in the kitchen area. The activity assistant left the cottage to obtain ice and upon her return began washing the dishes from the morning meal. CNA #1 returned to the cottage at 11:35 AM. At 11:39 AM the life enrichment coordinator entered the cottage and began assisting with the meal service. At 11:51 AM the maintenance director entered the cottage and began assisting with meal service.</p> <p>b. Observation on 3/19/24 at 11:23 AM showed elder #2 was sitting in his/her wheelchair accompanied by his/her representative. Interview with the elder's representative at that time revealed the elder had dementia and slept a lot. The representative stated he had been asking to have the elder transferred to a recliner for "1 and 1/2 hours" with no response. The elder's representative was becoming upset with the staff using a raised voice when speaking. At 11:27 AM the elder's representative asked CNA #2 again to transfer the resident to a recliner. CNA #2 stated her care partner was on break and she was unable to transfer the elder by herself. The elder was transferred to the recliner at 11:41 AM and then at 12:16 PM was transferred back to his/her wheelchair and brought to the dining room table for the noon meal.</p> <p>c. Observation on 3/19/24 at 11:43 AM</p> | F 725                                                               |                                                                                                                          |                            |                                                      |



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                          |                            |                                                      |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |                            | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                         |                            |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                      |
| F 725                                                               | <p>Continued From page 9</p> <p>showed CNA #1 and CNA #2 entered elder #6's room and closed the door. The CNAs exited the room at 12:04 PM and brought the resident to the dining table for the noon meal. The nurse assigned to the cottage was observed to go in and out of the room two times from 11:43 AM to 12:04 PM.</p> <p>d. Interview with CNA #1 on 3/19/24 at 3:20 PM revealed the census of Scott Cottage was 10 with 2 independent elders, 2 elders which required toileting/transferring assistance, and 6 elders which were dependent on 2 staff members for assistance. Two elders required assistance with eating. The CNA stated there were days that there was not enough time to do all of the tasks they were responsible for. In addition, the CNA stated the mid-shift staff member called off, and administration stepped in to help, which was not "typical".</p> <p>e. Interview with CNA #2 on 3/19/24 at 3:35 PM revealed mornings at the cottage were "crazy" and when the night shift CNAs did not do the preparation for the morning meal it put them behind.</p> <p>f. Interview with the life enrichment coordinator (LEC) on 3/19/24 at 4 PM revealed she thought 3 CNAs should be scheduled for Scott Cottage at all times due to the amount of time the CNAs needed to care for the elders. The LEC stated it took the CNAs at least 30 to 45 minutes to care for elder #2 at times. Further, the LEC stated she had obtained her CNA license; however, she only worked part-time at the facility.</p> <p>g. Review of the daily staff posting for Scott Cottage from 2/2/24 to 3/19/24 (47 days) showed the cottage was staffed during the day with 2 CNAs on 12 days; 3 CNAs on 22 days; 4 CNAs on 2 days; and 11 days were not documented. During the night shift the cottage was staffed with</p> | F 725                                                               |                                                                                                                          |                            |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                          |  |                                                                        |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>535054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE</b><br><b>SHERIDAN, WY 82801</b>                           |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 725                                                                      | <p>Continued From page 10</p> <p>2 CNAs on 36 days; 3 CNAs on 2 days; 4 CNAs on 1 day; and 8 days were not documented.</p> <p>Related to the general facility:</p> <p>1. Interview with the SW on 3/19/24 at 2:31 PM revealed at the beginning of February nine CNAs submitted their resignations on the same day, citing an issue related to a member of the management team. Further, the SW stated the board of trustees were aware of the concern and an investigation was started.</p> <p>2. Interview with the CEO on 3/20/24 at 12:03 PM confirmed 9 CNAs resigned giving two week's notice at the beginning of February. The CNAs had voiced a grievance with the board of trustees present. The board immediately placed the CNAs on administrative leave; not allowing them to fulfill the 2 week's notice.</p> <p>3. Review of the payroll hours report provided by the facility showed the following concerns:</p> <p>a. CNA #3 worked from 5:56 AM to 4:15 PM with no lunch on 2/1/24 and then worked from 11:52 PM until 6:36 AM on 2/2/24 for a total of 17.06 hours. In addition, the CNA worked 58.48 hours the week of 2/4 to 2/10; 48.9 hours the week of 2/11 to 2/17; 52.25 hours from 2/18 to 2/24; 62.35 hours from 2/25 to 3/2; and 61.8 hours from 3/3 to 3/9. Interview with the CNA on 3/19/24 at 5:45 PM confirmed she worked a lot of hours and stated "it takes its toll".</p> <p>b. CNA #4 worked 70.68 hours the week of 2/4 to 2/10; 37.03 hours the week of 2/11 to 2/17; 64.92 hours the week of 2/18 to 2/24; 49 hours the week of 2/25 to 3/2; and 39.76 hours the week of 3/3 to 3/9.</p> <p>c. CNA #1 worked 22 hours the week of 2/18</p> | F 725                                                                      |                                                                                                                          |  |                                                                        |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                      |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                              |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                                                  |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                          |  | (X5)<br>COMPLETION<br>DATE                           |
| F 725                                                               | Continued From page 11<br>to 2/24; 24.92 hours the week of 2/25 to 3/2;<br>24.79 hours the week of 3/3 to 3/9; and 24.92<br>hours the week of 3/10 to 3/16. Interview with the<br>CNA on 3/19/24 at 3:20 PM revealed she was<br>agency staff.<br>d. CNA #2 worked 56.44 hours the week of<br>3/3 to 3/9 and 61.83 hours the week of 3/10 to<br>3/16. Interview with CNA #2 on 3/19/24 at 3:35<br>PM revealed she had been employed by the<br>facility since 3/2/24.<br><br>4. Interview with the human resource director<br>(HRD) on 3/20/24 at 11:14 PM revealed the<br>full-time CNAs normal working schedule included<br>36 hours one week with a mandatory 48 hours<br>the following week. When the facility needed a<br>shift staffed, a notice would be sent out<br>electronically to the staff requesting volunteers.<br>Further the HRD stated the facility currently had 2<br>agency staff and 3 full-time CNA openings. He<br>stated the scheduling for CNA #1 was an error<br>and she should have been scheduled for more<br>than 2 shifts per week. | F 725                                                               |                                                                                                                                                                                                                                                                                                                                                                   |  |                                                      |
| F 732<br>SS=B                                                       | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility<br>must post the following information on a daily<br>basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked<br>by the following categories of licensed and<br>unlicensed nursing staff directly responsible for<br>resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F 732                                                               | F732 Posted nurse staffing information.<br><br>It is the policy of this facility to ensure the<br>highest quality of care for all of our Elders.<br>Consistent with this practice, the following<br>has been done. No resident was found to be<br>affected by the deficient practice; however,<br>there is the potential for all the residents to be<br>affected. |  |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                        |
|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>535054</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE<br/>SHERIDAN, WY 82801</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | (X5)<br>COMPLETION<br>DATE                                             |
| F 732                                                                      | <p>Continued From page 12</p> <p>vocational nurses (as defined under State law).<br/>(C) Certified nurse aides.<br/>(iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements.<br/>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br/>(ii) Data must be posted as follows:<br/>(A) Clear and readable format.<br/>(B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on review of the posted nurse staffing data and staff interview, the facility failed to ensure the posted 24/7 hour nursing staff included all required information. The census was 38. The findings were:</p> <p>1. Review of the 2/1/24 to 3/18/24 daily nurse staffing information for Founders Cottage showed the following concerns:<br/>a. Review of 14 out of 47 days (2/11, 2/12, 2/13, 2/16, 2/17, 2/21, 2/22, 2/26, 2/27, 2/29, 3/1, 3/2, 3/6, 3/18) failed to include the elder census, the total number and actual hours worked by the</p> | F 732                                                                      | <p>1. All of nurse staffing information forms will be placed in all GHIL houses and will include the following information:<br/>a. Facility name<br/>b. Current date<br/>c. Total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift<br/>I. Registered nurses<br/>II. Licensed practical nurses or vocational nurses<br/>III. Certified nurse aides<br/>IV. Elder census</p> <p>Nurse staffing information forms will be audited daily by Guide or appointed agent x 1 month.</p> <p>2. All Elders could be affected by failure to post nurse staffing information. DON or designee will do a random sample of 5 Elders per week x one month to evaluate the effectiveness of posted staffing ratios.</p> <p>3. Nurse staffing information forms will be audited to ensure completion by Guide or appointed agent weekly x 3 months.</p> <p>4. Data for the audits will be presented to the Facilities/QAPI meeting monthly x 3 months. The DON and/or Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on:</p> |  | 05/04/2024                                                             |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |                                                                                                                                                                                                                                                                                                                                        |  |                                                      |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                       |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                               |  | (X5)<br>COMPLETION<br>DATE                           |
| F 732                                                               | Continued From page 13<br>CNAs, registered nurses, and the licensed<br>practical nurses per shift.<br><br>2. Review of the 2/2/24 to 3/18/24 daily nurse<br>staffing information for Scott Cottage showed the<br>following concerns:<br>a. Review of 14 out of 46 days (2/4, 2/5, 2/8,<br>2/11, 2/13, 2/17, 2/18, 3/3, 3/4, 3/5, 3/10, 3/16,<br>3/17, 3/18) failed to include the elder census, the<br>total number and actual hours worked by the<br>CNAs, registered nurses, and the licensed<br>practical nurses per shift.<br><br>3. Review of the 2/1/24 to 3/18/24 daily nurse<br>staffing information for Whitney Cottage showed<br>the following concerns:<br>a. Review of 29 out of 47 days (2/2, 2/4, 2/5,<br>2/6, 2/7, 2/8, 2/9, 2/11, 2/12, 2/13, 2/14, 2/20,<br>2/21, 2/27, 2/28, 3/4, 3/5, 3/6, 3/8, 3/9, 3/10, 3/11,<br>3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18) failed to<br>include the elder census, the total number and<br>actual hours worked by the CNAs, registered<br>nurses, and the licensed practical nurses per<br>shift.<br><br>4. Interview with the DON on 3/19/24 at 2:56 PM<br>confirmed the daily nurse staffing data<br>information posts were incomplete. | F 732                                                               |                                                                                                                                                                                                                                                                                                                                        |  |                                                      |
| F 837<br>SS=F                                                       | Governing Body<br>CFR(s): 483.70(d)(1)(2)<br><br>§483.70(d) Governing body.<br>§483.70(d)(1) The facility must have a governing<br>body, or designated persons functioning as a<br>governing body, that is legally responsible for<br>establishing and implementing policies regarding<br>the management and operation of the facility; and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 837                                                               | F837 Governing Body<br><br>It is the policy of this facility to ensure the<br>highest quality of care for all our Elders.<br>Consistent with this practice, the following<br>has been done. No resident was found to be<br>affected by the deficient practice; however,<br>there is the potential for all residents to be<br>affected. |  |                                                      |

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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                      |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETION<br>DATE                           |
| F 837                                                               | <p>Continued From page 14</p> <p>§483.70(d)(2) The governing body appoints the administrator who is-</p> <p>(i) Licensed by the State, where licensing is required;</p> <p>(ii) Responsible for management of the facility; and</p> <p>(iii) Reports to and is accountable to the governing body.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of the Wyoming Administrative Rules, Nursing Home Administrators, Chapter 2: Licensure Requirements, the facility assessment, the Wyoming Healthcare Facility Change Form, and staff and board of trustee interview, the facility failed to appoint a licensed, administrator as established by the Wyoming Board of Nursing Home Administrators. The census was 38. The findings were:</p> <p>1. Review of the Wyoming Nursing Home Administrators Chapter 2 Rules, effective 12/19/19, showed "Section 1. License Required. No individual shall perform any function specifically authorized for a Nursing Home Administrator nor function as a Nursing Home Administrator nor represent himself as a Nursing Home Administrator unless licensed by the Board."</p> <p>2. Review of the Wyoming Department of Health "Healthcare Facility Change in Personnel/E-mail Address Form", dated, 2/13/23, showed the CEO was named as the new Administrator/Director. The form did not include a Wyoming professional license number.</p> <p>3. Review of the facility assessment, last updated on 1/29/24, showed "Part 3: Facility Resources</p> | F 837                                                               | <p>1. The current Board of Directors became aware on 3/15/2024 of the failure to meet the regulation F837 by hiring an administrator without an active license and took immediate action to remove CEO from administrator position. As stated in #2 of findings of state survey that the Healthcare Facility Change in Personnel Address Form did not include a Wyoming professional license number as CEO was not licensed in the state of Wyoming for this practice.</p> <p>The Board of Directors will recruit and appoint a Nursing Home Administrator licensed by the Wyoming Board of Nursing Home Administrators who meets qualifications as stated in Administrator Job Description. Will update Administrator Job to Nursing Home Administrator.</p> <p>2. All Elders could be affected by the failure to meet regulation that the governing body, the GHL Board of Directors, to appoint a licensed administrator.</p> <p>3. The Governance Committee and the Board President on the GHL Board of Directors will ensure that Nursing Home Administrator is licensed by the Wyoming Board of Nursing Home Administrators. Governance Committee will report to the Board of Directors on status of licensed Nursing Home Administrator on a monthly basis for 3 months.</p> |  | 05/04/2024                                           |



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

PRINTED: 04/03/2024  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     |                                                                                                                          |  |                                                      |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>535054 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801                                         |  |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                           |
| F 837                                                               | <p>Continued From page 15</p> <p>Needed to Provide Competent Support and Care for our Elder Population Every Day and During Emergencies Staff type 1.1 Outlined below are the type of staff members, other health care professionals, and medical practitioners that we have identified are needed to provide support and care for our elders." A CEO was listed as being on-staff; however, there was no evidence the facility employed a NHA.</p> <p>4. The facility was unable to locate a job description for the CEO or NHA.</p> <p>5. Interview with the CEO on 3/19/24 at 12:39 PM revealed her title was CEO and she did not have a license from the Wyoming Board of Nursing Home Administrators.</p> <p>6. Interview with the president of the Board of Directors on 3/19/24 at 3 PM revealed the board had recently become aware of the regulation and was taking immediate action. Further, the president stated the CEO had been acting as the nursing home administrator since February of 2023.</p> | F 837                                                               |                                                                                                                          |  |                                                      |

Healthcare Licensing and Surveys

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>WY00042                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>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) COMPLETE DATE                                |
| S 000                                                               | <p><b>OPENING COMMENTS</b></p> <p>Rules and Regulations utilized for this survey are:</p> <p>Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 07/01/2020</p> <p>Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000</p> <p>A complaint survey was conducted from 3/19/24 to 3/20/24. The survey was prompted by complaint intakes</p> <p>WY00003792, WY00003798, WY00003805, WY00003811, WY00003814, WY00003818, WY00003819, WY00003792.</p> <p>The following common abbreviations are used throughout the document:</p> <p>CEO: Chief Executive Officer<br/>NHA: Nursing Home Administrator</p> <p>Less commonly used abbreviations will be annotated in each deficiency.</p> | S 000                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   |
| S2900                                                               | <p>Ch 11 Sec 5(a) Organization and Administration</p> <p>(a) Governing Body. The Nursing Care Facility shall have a governing body which has the legal authority and responsibility to operate the Nursing Care Facility. The governing body shall:</p> <p>(i) Appoint a full-time, on premise, administrator qualified by education, training and experience as established by the Wyoming Board of Nursing Home Administrators.</p> <p>(A) The administrator shall have a current license as a Wyoming Licensed Nursing Home Administrator.</p>                                                                                                                                                                                                                             | S2900                                                                            | <p>S2900 Organization and Administration</p> <p>It is the policy of this facility to ensure the highest quality of care for all our Elders. Consistent with this practice, the following has been done.</p> <p>1. The current Board of Directors became aware on 3/15/2024 of the failure to meet the regulation S2900 by hiring an administrator without an active license and took immediate action to remove CEO from administrator position.</p> |                                                   |

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4-12-24

STATE FORM

6602

P74X11

If continuation sheet 1 of 4

PUC accepted. PUC 5/1/24. Spoke to Elizabeth Maguire  
on 4/24/24 @ 1:58pm  
Jared G

Healthcare Licensing and Surveys

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                   |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>WY0042                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>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) COMPLETE DATE                                |
| S2900                                                               | Continued From page 1<br><br>(ii) Temporary License. A temporary license may be granted by the Wyoming Board of Nursing Home Administrators:<br><br>(A) To fill a position of Nursing Home Administrator that unexpectedly becomes vacant;<br><br>(B) For a period not to exceed six (6) months;<br><br>(C) After consideration by the Board of Nursing Home Administrators on an individual basis; and<br><br>(D) To an individual who does not meet all the licensing requirements under the Act, but who is of good character and meets the educational requirements as stated.<br><br>(iii) A temporary license may be renewed for good cause for one (1) time if requested thirty (30) days prior to the termination of the initial temporary license.<br><br>(iv) The administrator of a hospital with a connection nursing care wing can serve as the administrator and shall be licensed as a Wyoming Nursing Home Administrator.<br><br>(v) The administrator shall enforce the rules and regulations relative to the level of health care and safety of residents and for the protection of their personal and property rights.<br><br>(vi) The administrator shall plan, organize, and direct those responsibilities delegated to him by the governing body or its equivalent. | S2900                                                                            | As stated in #1 of findings of state survey that the Healthcare Facility Change in Personnel Address Form did not include a Wyoming professional license number as CEO was not licensed in the state of Wyoming for this practice.<br><br>The Board of Directors will recruit and appoint a Nursing Home Administrator licensed by the Wyoming Board of Nursing Home Administrators who meets qualifications as stated in Administrator Job Description. Will update Administrator Job to Nursing Home Administrator.<br><br>2. All Elders could be affected by the failure to meet regulation that the governing body, the GHL Board of Directors, to appoint a licensed administrator.<br><br>3. The Governance Committee and the Board President on the GHL Board of Directors will ensure that Nursing Home Administrator is licensed by the Wyoming Board of Nursing Home Administrators. Governance Committee will report to the Board of Directors on status of licensed Nursing Home Administrator on a monthly basis for 3 months. | 05/04/2024                                        |

Healthcare Licensing and Surveys

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                  |                                                                                                                          |                                                      |
|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>WY00042             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>03/20/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>GREEN HOUSE LIVING FOR SHERIDAN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2311 SHIRLEY COVE<br>SHERIDAN, WY 82801 |                                                                                                                          |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                             |
| S2900                                                               | <p>Continued From page 2</p> <p>(vii) An employee of the facility shall be authorized in writing to act on the administrator's behalf during his/her absence.</p> <p>This State Rule and Regulation is not met as evidenced by:<br/>Based on staff interview, review of the facility assessment and the Wyoming Healthcare Facility Change Form, the facility failed to appoint a full-time administrator qualified by education, training and experience as established by the Wyoming Board of Nursing Home Administrators. The census was 38. The findings were:</p> <p>1. Review of the Wyoming Department of Health "Healthcare Facility Change in Personnel/E-mail Address Form", dated, 2/13/23, showed the CEO was named as the new Administrator/Director. The form did not include a Wyoming professional license number.</p> <p>2. Review of the facility assessment, last updated on 1/29/24, showed "Part 3: Facility Resources Needed to Provide Competent Support and Care for our Elder Population Every Day and During Emergencies Staff type 1.1 Outlined below are the type of staff members, other health care professionals, and medical practitioners that we have identified are needed to provide support and care for our elders." A CEO was listed as being on-staff; however, there was no evidence the facility employed a NHA.</p> <p>3. The facility was unable to locate a job description for the CEO or NHA.</p> <p>4. Interview with the CEO on 3/19/24 at 12:39 PM revealed her title was CEO and she did not have a license from the Wyoming Board of Nursing</p> | S2900                                                                            |                                                                                                                          |                                                      |

Healthcare Licensing and Surveys

|                                                                            |                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                          |                          |                                                                    |
|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>WY0042</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/20/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREEN HOUSE LIVING FOR SHERIDAN</b> |                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2311 SHIRLEY COVE</b><br><b>SHERIDAN, WY 82801</b> |                                                                                                                          |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| S2900                                                                      | Continued From page 3<br><br>Home Administrators.<br><br>5. Interview with the president of the Board of Directors on 3/19/24 at 3 PM revealed the board had recently become aware of the regulation and was taking immediate action. Further, the president stated the CEO had been acting as the nursing home administrator since February of 2023. | S2900                                                                                          |                                                                                                                          |                          |                                                                    |