

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

PRINTED: 08/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04 B. WING _____		(X3) DATE SURVEY COMPLETED R 05/01/2024
NAME OF PROVIDER OR SUPPLIER GREEN HOUSE LIVING FOR SHERIDAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}			
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted via email on 05/01/2024 for all previous deficiencies cited on 01/30/2024, 03/06/2024, and 04/17/2024. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.90.	{K 000}			
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted via email on 05/01/2024 for all previous deficiencies cited on 01/30/2024, 03/06/2024, and 04/17/2024. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.90.	{K 000}			
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted via email on 05/01/2024 for all previous deficiencies cited on 01/30/2024, 03/06/2024, and 04/17/2024. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all requirements in accordance with 42 CFR 483.90.	{K 000}			
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted via email on 05/01/2024 for all previous deficiencies cited on 01/30/2024, 03/06/2024, and 04/17/2024. All deficiencies have been corrected, and no new noncompliance was found. The	{K 000}			

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

TITLE

(X6) DATE

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.

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

PRINTED: 08/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 02, 03, 04 B. WING _____		(X3) DATE SURVEY COMPLETED R 05/01/2024
NAME OF PROVIDER OR SUPPLIER GREEN HOUSE LIVING FOR SHERIDAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2311 SHIRLEY COVE SHERIDAN, WY 82801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page 1 facility is in compliance with all requirements in accordance with 42 CFR 483.90.	{K 000}			