STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535054	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HOUSE LIVING FOR SHERIDAN	**2311 SHIRLEY COVE SHERIDAN, WY 82801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/10/25 through 3/13//25. Also reviewed in the course of the survey was complaint intake WY00004078. The following common abbreviations are used throughout this document: RN: Registered Nurse DON: Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set LPN: Licensed Practical Nurse PRN: As Needed Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		4/18/25

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

Electronically Signed | 04/06/2025

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.

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure residents were treated with respect and dignity in 1 of 4 resident cottages (Scott). The cottage census was 7. The findings were: 1. Observation on 3/11/25 at 4:47 PM showed seven residents and two resident family members were seated at the dining table. At that time, two CNAs, CNA #1 and CNA #2, were discussing resident health information at a volume that could easily be heard across the room. CNA #1 asked resident #3 how many bowel movements s/he had that day and the resident held up two fingers. Then the CNA asked CNA #2, "How many times	F 550	Deficiency Identified: SGH was found to have deficient practices related to F550 Resident Rights. Facility failed to ensure residents were treated with respect and dignity. It was observed that Certified Nursing Assistants (CNAs) were discussing residents□ health information at a volume that could easily be heard across the room. Specific instances included CNAs openly asking residents about their bowel movements in a manner that did not ensure privacy. Root Cause Analysis: The root cause of this deficiency is a lack	

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F 550	Continued From page 2 did you change [resident #18]?" CNA #2 replied, "Four times." 2. Observation on 3/12/25 at 4:25 PM showed three residents seated at the dining table. Two CNAs, CNA #2 and CNA #3, were discussing resident health information and CNA #2 stated loudly from the other side of the room, "the nurse said she'll mark all of [resident #4]'s smearing as a small BM." 3. Interview with the administrator and DON on 3/13/25 at 9:35 AM revealed they expected staff to ask about private matters privately, not in front of other residents or visitors, because it was personal information. They confirmed discussing private health information at the dining table was not an appropriate type of interaction with residents and could be undignified. 4. Review of facility policy titled "Elder Dignity and Respect Policy" last updated 11/21/23 shows "Elders shall always be treated with dignity and respect..." and "Staff shall maintain an environment in which confidential clinical information is protected, for example 'Verbal staff-to-staff communication (e.g. change of shift reports) shall be conducted outside the hearing range of elders and the public...'"	F 550	of adequate staff training on resident rights, particularly regarding the importance of maintaining dignity, respect, and confidentiality when discussing residents health information. Residents at Risk: All residents are at potential risk if staff do not properly safeguard their private health information and uphold their dignity. Special attention will be given to residents who may be particularly vulnerable due to cognitive impairments or communication barriers. Corrective Actions: Staff Education: All direct care staff, including CNAs, nurses, and other team members, will receive mandatory training on resident rights, with a focus on dignity, self-determination, respect, and the protection of confidential health information. This training will cover proper communication techniques, HIPAA regulations, and best practices for discussing personal health matters in a private and respectful manner. Training sessions will be conducted by the Director of Nursing (DON) or a designated educator; competency will be demonstrated through verbal and written assessments. This will be completed by April 18, 2025. Monitoring and Reinforcement: DON and/or designated household staff	

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F 550	Continued From page 3	F 550	will conduct random audits and observations to ensure staff compliance with privacy protocols. Residents and their families will be encouraged to report any concerns regarding breaches of dignity and confidentiality. Immediate corrective action will be taken for any staff members observed violating resident rights. Compliance Date: All corrective actions and training will be completed by 4/18/2025. Results of the audits will be presented at the monthly QAA meeting, every month for three months. Ongoing monitoring will continue to sustain improvements. Responsible Person(s): Director of Nursing (DON): Responsible for implementing staff training and monitoring compliance. Administrator: Oversees the overall compliance and ensures adherence to facility policies. DON and/or Designee: Responsible for direct staff supervision and real-time correction of any breaches.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		4/18/25

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F 679	Continued From page 4 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, activity calendar review, and policy and procedure review, the facility failed to ensure resident choice of activities were provided for 3 of 4 resident cottages (Scott, Watt, Founders) with activity concerns. The findings were: 1. Review of the activity calendar for March 2025 showed on 3/12/25 the scheduled activities were 10 AM activities binder exercise "CNA pick and assist" and 2 PM Dominos in Watt game room. Further review showed the "PM" activity every day was "This day in History reading by staff (read at lunch or dinner)." 2. Review of the quarterly MDS assessment dated 1/16/25 showed resident #6 had a brief interview for mental status (BIMS) score of 15 out 15, which indicated the resident was cognitively intact, and had diagnoses which included depression. Review of the annual MDS assessment dated 10/16/24 showed it was very important to have books, newspapers, and magazines to read, listen to music, be around animals, keep up with the news, do his/her favorite activities, and participate in religious services or activities. Review of an	F 679	Deficiency Identified: SGH was found to have deficient practice related to F679 Activities Meet Interest/Needs Each Resident. The facility failed to ensure resident choice of activities were provided. Root Cause Analysis: Expectations of the activities program with roles and responsibilities and documentation practices are not clearly outlined. There is no consistent process to evaluate that the program is satisfactory for the elders. There is no consistent process to ensure each cottage has the resources needed to carry out the activity program for the day. Residents at Risk: All elders are affected by the activities program. Corrective Actions: 1) Standard work will be written reflecting the current expectations, roles/responsibilities, documentation practices of the activities program. This will be written by the Activities Director and educated to all household staff by 4/18/2025.	

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F 679	Continued From page 5 "Activities-Quarterly/Annual Participation Review" dated 3/18/24 showed the resident enjoyed both group and individual activities, facility events and celebrations, crafts appropriate for his/her age, and music when piano players visited the facility. Review of the resident's care plan last revised on 1/20/25 showed the resident enjoyed art activities and helping with household duties such as cooking and prepping food and wanted to participate in streaming exercise. Further review showed "I enjoy music. I enjoy crafts projects that have a purpose. For example, card making, jewelry making, etc. I enjoy socializing with others but also enjoy my alone time because I grew up as an only child and I find it relaxing." The following concerns were identified: a. Interview with the resident on 3/11/25 at 10:04 AM revealed the facility no longer performed activities in the cottage and s/he did most of his/her activities alone in the room. b. Observation on 3/12/25 from 9:03 AM to 9:18 AM showed a staff member was playing cards at the dining room table with 2 residents in the Founders cottage when resident #6 arrived at the table for breakfast. Further observation showed resident #6 was not invited to play cards at that time. Upon completion of breakfast at 9:18 AM, the resident returned to his/her room. Observation from 9:33 AM to 12:09 PM showed no activities were performed in the Founders cottage. Observation at 9:08 AM showed resident #6 arrived at the dining table positioned him/herself up to the dining table. Further observation showed the resident was not offered to participate in the card game being played between a staff member and another resident. c. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in "Coffee and Visit" 6 times,	F 679	2) Activities Director will round with each cottage each weekday to ensure they have the resources and the plan to carry out the planned activities for the day. Any anticipated barrier will be addressed or escalated to leadership for assistance. This will begin week of 4/19/25. 3) A sign in sheet will be made available by the activities director in each household binder and be collected by household staff at each group activity which will capture that each elder was invited to attend, who participated in the activity, the length of time of the activity, and whether the activity was Love it (thumbs up), can live with it (thumb neutral), or could do without it (thumbs down). This will begin by 4/18/25. Goal will be to achieve 90% compliance with use of sheet within 90 days. 4) Activities director will collect sign in sheets to conduct daily audit that activity was completed and documented by household staff and monitor for overall approval of activities programs by the elders. a. Items voted as thumbs down or with low participation will be brought to the Elder Committee meeting(s) to determine whether to continue with offering the activity in the future or to identify improvements to increase participation. b. b. Incomplete documentation will be entered by activities director. Staff will be coached for compliance. Goal of 90%	

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F 679	Continued From page 6 "Conversation" 21 times, and "Current Events" 8 times. Further review showed no other activities were attended. 3. Review of the quarterly MDS assessment dated 1/6/25 showed resident #11 had BIMS score of 4 out 15, which indicated severe cognitive impairment and diagnoses which included Alzheimer's disease and major depressive disorder. Review of the annual MDS assessment dated 10/6/24 showed it was very important to listen to music s/he liked, keep up with the news, do things with groups, do his/her favorite activities, and go outside to get fresh air when the weather was good. Review of an "Activities-Quarterly/Annual Participation Review" dated 3/14/24 showed the resident enjoyed painting, watching television, and enjoys the company of other residents when s/he can hear them. Review of the resident's care plan last revised on 1/29/24 showed "Ensure that the activities I am attending are: Compatible with my physical and mental capabilities; Compatible with my known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with my individual needs and abilities; and age appropriate...I like spending time with staff 1:1. I would like to be assisted to my painting area, and paint. I like doing art related projects also...I need assistance/escort to activity functions and assistance during activities...Invite me to scheduled activities. Provide a program of activities that is of interest and empowers me by encouraging/allowing choice, self-expression and responsibility. Notify me of any changes to the calendar of activities..." The following concerns were identified: a. Observation on 3/12/25 from 9:02 AM to	F 679	completion/documentation of activities within 90 days. 5) Activities calendar will be approved by the Elder Committee in advance of implementation. 6) Individual Activities participation data will be collected from PCC documentation and discussed at each care conference to ensure elder is satisfied with offerings and elicit feedback for improvement. Monitoring/Sustainment: Implementation of the above plan will be carried out by Activities Director. Compliance with implementation timeline will be reported to QAA committee. Compliance rate with use of tools and documentation will be reported to QAA committee; goal of 90% completed accurately within 90 days. Data findings will be shared in a report to QAA committee, quarterly, including participation rates and interventions identified. Compliance Date: 4/18/25 Responsible Person(s): Activities Director	

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F 679	Continued From page 7 9:33 AM showed resident #11 was seated at the dining table in the Founders cottage, playing cards with another resident and a staff member. Observation at 9:36 AM showed CNA #4 assisted the resident to his/her room. Observation at 9:44 AM showed CNA #4 assisted the resident to the common area and into a recliner. Observation from 9:44 AM to 11:07 AM showed the resident remained in the recliner. Observation at 11:46 AM showed CNA #4 assisted the resident to stand and ambulate to the dining table. No activities were performed from 9:33 AM to 12:09 PM. b. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in "Coffee and Visit" 3 times, "Conversation" 33 times, and "Current Events" 2 times. Further review showed no other activities were attended. 4. Review of the annual MDS assessment dated 1/11/25 showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Further review showed it was very important to be around animals and go outside for fresh air when the weather was good, and somewhat important to have books newspaper, and magazines to read, keep up with the news, and do his/her favorite activities. Review of the resident's care plan last revised on 12/18/24 showed "I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside..." The following concerns were identified: a. Observation in the Watt cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection.	F 679		

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F 679	Continued From page 8	F 679		

Observation at 4:57 PM showed the resident was attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away. Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. Observation at 4:59 PM showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. Further observation showed Domino's was performed in the cottage from 1:34 PM to 1:58 PM which 3 residents from the cottage, which did not include resident #20, and 1 resident from another cottage attended. Further observation showed no additional activities were performed in the cottage.

b. Review of the activity participation record from 2/11/25 to 3/12/25 showed the resident participated in "Coffee and Visit" 1 time, "Conversation" 34 times, and "Current Events" 11 times. Further review showed no other activities were attended.

c. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the Watt Cottage should have a 1 to 1 for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. Further interview revealed at that time there was 1 CNA, the RN, and the patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors.

5. Review of the quarterly MDS assessment dated 1/9/25 showed resident #26 had a BIMS

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F 679	Continued From page 9	F 679		

score of 10 out 15, which indicated moderate cognitive impairment, and diagnoses which included depression. Review of the admission MDS assessment dated 10/9/24 showed it was very important for the resident to keep up with the news and somewhat important to have books, newspapers, and magazines to read and do his/her favorite activities. The following concerns were identified:

a. Review of the resident's care plan last revised on 1/5/25 showed no evidence the resident's activity preferences were identified.

b. Observation in the Watt cottage on 3/12/25 from 1:34 PM to 1:58 PM showed a Dominos game was performed in the cottage; however, the resident did not attend. Observation from 1:58 PM to 5 PM showed no other activities were performed in the cottage.

6. Review of annual MDS assessment dated 12/7/24 showed resident #3 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review showed it was very important to do things with groups of people and to do his/her favorite activities. Review of the resident's care plan, last updated 12/26/24, showed "[resident] likes to stay busy and attend lots of activities." Interventions included "Invite me to scheduled activities" and "Provide a program of activities that is of interest to me and empowers me by encouraging/allowing choice, self-expression and responsibility. My preferred activities are: group activities, crafts, music, outdoor activities, pet visits, community outings." The following concerns were identified:

a. Interview with the resident on 3/10/25 at 4:03 PM revealed s/he liked to go to bingo and dominoes but mostly spent time in his/her room doing solo activities. S/he stated s/he would like

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to learn how to crochet and that a staff member had begun to teach him/her but hadn't continued. S/he further stated, "Every time I ask for puzzles, they don't know where they're at."

b. Observation on 3/12/25 from 8:48 AM to 10:30 AM showed the activities board in Scott cottage said "10:00 AM activities binder"; however, no activities were observed taking place with any residents during that time period. Further observation on 3/12/25 at 2:04 PM showed resident #3 returned from playing dominoes at Watt cottage. S/he had been gone for approximately 30 minutes and was the only resident from Scott cottage who participated in the group activity.

7. Interview with LPN #1 and CNA #2 on 3/12/25 at 2:44 PM revealed the activities director almost never came to the houses to do activities with the residents. The interview further revealed they don't do bingo anymore, and they used to do that a lot. The previous activities director used to frequently come around and do 1:1 activities like playing a game or doing crafts. Activities and 1:1 time were very helpful for the residents in Watt and Founders cottages who wander. They really benefited from the 1:1 time and were a lot more calm and less likely to wander as a result.

8. Interview with the activities director on 3/13/25 at 8:54 AM revealed the staff in each cottage were expected to perform activities for the cottage and she expected them to follow the activity guidance provided in the activity binder. She revealed she expected to staff to do more activities than observed during the survey. Further interview revealed she did not feel staff could perform the activities tasks with the staffing levels of the facility.

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F 679	Continued From page 11 9. Review of the policy titled "Elder Preference of Activities" last updated 2/16/22 showed "...1. Elders are encouraged to choose the types of recreational, cultural, and religious activities and social events in which they prefer to participate..."	F 679		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to maintain acceptable parameters of nutritional status for 1 of 2 sample residents (resident #4) with nutritional status concerns. This failure resulted in harm to resident	F 692	Deficiency Identified: SGH was found to have deficient practices related to F692 Nutrition/Hydration Status Maintenance. Facility failed to maintain acceptable parameters of nutritional status for individual with nutritional status concerns.	4/18/25

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GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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F 692	Continued From page 12 #4 who experienced severe weight loss. The findings were: 1. Review of the annual MDS assessment dated 2/3/25 showed resident #4 had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment, and diagnoses which included dementia, depression, and chronic obstructive pulmonary disease. Review of the physician orders showed a regular fortified low sodium diet with snacks 3/8/23. Review of the resident's care plan last updated 2/15/25 showed the resident had the potential for unplanned weight loss related to eating small meals. Interventions included "Offer me snacks, and I do prefer ritz crackers. Encourage me to have small, frequent feedings instead of large meals. Give me supplements if needed to maintain adequate nutrition." The following concerns were identified: a. Review of resident's weight history showed the resident weight had decreased from 88.5 lbs. on 2/1/25 to 82.0 lbs. on 3/2/25, a 7.34% weight loss, which was a severe weight loss in one month. b. Observation on 3/11/25 at 8:28 AM showed the resident was seated in his/her wheelchair at the breakfast table eating without assistance. The resident was very thin appearing with hollow cheeks and temples. c. Observation on 3/12/25 from 8:48 AM to 10:30 AM showed the resident was seated in his/her wheelchair at the breakfast table. The breakfast plates had been cleared; however, the resident remained at the table for over 90 minutes. During that time, the resident was offered coffee; however, no snacks were offered or provided. d. Observation on 3/12/25 from 2:04 PM to 4:25 PM showed the resident was seated at the	F 692	Root Cause Analysis: Risk for unintentional weight loss was identified, interventions were identified and not consistently followed or monitored for effectiveness. Severe weight loss then occurred without further intervention. There is no consistent and reliable process to ensure appropriate monitoring and intervention occurs. Opportunity to improve use of PCC features to ensure elders specific needs are communicated and monitored such as weight monitoring and offering snacks. Residents at Risk: Without consistent processes for monitoring and communication of interventions, all elders are at risk. Corrective Actions: 1.)All care plans will be audited and updated to ensure they reflect elders preferences and specific nutritional needs at present. All charts will be audited to ensure tasks ensuring documentation of meal and snack intake are appropriately activated to capture every meal and snack offering and intake. Completed by 4/18/25, completed by RDN. 2.) All elders will be weighed weekly x 4 weeks to identify any elders with current weight loss trends. Completed by by nursing staff and starting the week of 4/13/2025. 3.) All elders with weight loss concerns will continue to be monitored weekly.	

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F 692	Continued From page 13 table in his/her wheelchair. No snacks were provided or offered during that time. e. Review of snack documentation from 2/12/25 to 3/12/25 showed no documentation the resident was offered or accepted PRN snacks. f. Review of a progress note dated 3/5/25 at 3:32 PM showed "[Resident #4] has continued to lose weight and has triggered for a 5% weight loss in 30 days. [S/he] will be weighed weekly for 4 weeks to monitor weight...RD has encouraged snacks such as cookies with butter, peanut butter on cookies and desserts after each lunch and dinner." 2. Interview with dietitian on 3/13/25 at 10:40 AM revealed her expectation for staff was to offer snacks to the resident, especially between lunch and dinner. She stated, "[Resident #4] will never turn down a cookie. If you offer [him/her] string cheese, [s/he] will turn it down. [S/he] might turn down a nutritional supplement, but s/he would not turn down a milkshake." Further interview confirmed offering snacks to the resident was not currently a task in the resident's medical record. 3. Review of facility policy titled "Weight Assessment and Intervention Policy" last reviewed 5/23/22 showed "...5% weight loss [in one month] is significant; greater than 5% is severe" and "care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the dietician, the consultant pharmacist, and the elder or elder's legal surrogate. Individualized care plans shall address to the extent possible: a. the identified causes of weight loss, b. goals and benchmarks for improvement, c. time frames and parameters for monitoring and reassessment..."	F 692	Those without weight loss concerns may proceed with monthly weights unless another medical condition requires weights to be more frequently or elder prefers to be weighed more frequently. All weight tasks and frequency of assingments will be updated in PCC by RDN. 4.) Standard work for monitoring weight and nutrition will be written to include: a. RDN will monitor weight trends and meal and snack intake weekly and further assess downward trends in intake and/or weight loss of 2% or more in one month. Recommendations for intervention will be documented in the medical record and care plan and clinical tasks will be updated to reflect recommendations. b. Any weight loss of 5% or more in 1 month, 7.5% or more in 3 months, or 10% or more in 6 months will be considered a significant change. The MDS nurse will be notified and a care conference will be arranged for IDT to further address. Standard Work will be written by RDN and implemented by 4/18/2025. 5.) All household staff will be educated,by RDN, on appropriate techniques for obtaining weight and documentation expectation and practices by 4/18/2025. Monitoring/Sustainment: RDN will monitor for process implementation compliance and improved outcomes. Goal for	

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F 692	Continued From page 14	F 692	individuals experiencing weight loss to reduce by 25% facility-wide, within 90 days. Process compliance monitored through daily audit of documentation of snack offering/intake and meal intake with goal of 90% compliance within 30 days. Compliance and outcomes to be reported to Administrator and QAA team on a monthly basis. Compliance Date: Processes implemented by 4/18/2025.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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 §483.71. §483.35(a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		4/18/25

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F 725	Continued From page 15 §483.35(a)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident representative, and resident interview, and facility staffing review, the facility failed to ensure adequate staff in 1 of 4 cottages (Watt). The cottage census was 9. The findings were: 1. Review of the annual MDS assessment dated 1/11/25 showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Review of the resident's care plan last revised on 12/18/24 showed "I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside..." Further review showed "I may have behaviors of being verbally mean or getting agitated [related to] dementia" and "I may wander or try to leave my cottage r/t History of attempts to leave facility unattended." The following concerns were identified: a. Observation in the Watt cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection. Observation at 4:57 PM showed the resident attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away. Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. b. Observation on 3/12/25 at 4:59 PM	F 725	Deficiency Description: SGH was found to have deficient practices related to F725 □ Sufficient Nursing Staff. It was observed that staff were having difficulty completing all assigned tasks because a significant amount of time was devoted to one resident with severe dementia. This high-needs situation has diverted staffing resources from other essential care duties. Root Cause: The root cause of this deficiency is an imbalance between resident care needs and staffing assignments. Specifically, the facility□s staffing model did not fully account for the high acuity of residents with severe dementia. As a result, the intensive care required by one resident has created staffing constraints, leading to insufficient available staff for other tasks. Residents at Risk: Residents at highest risk are identified to be those residing in the Watt cottage. Risk to other cottages occurs if current staffing patterns and work flows are unable to sustain the need for increased supervision in the Watt cottage. Corrective Actions: 1. Immediate Reassignment and	

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F 725	Continued From page 16 showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. c. Review of a progress note dated 3/10/25 and timed 3:47 AM showed "Elder was very restless last evening, and at times even agitated and combative. He took [his/her] medications mixed in ice cream, but no effect noted. In earlier part of shift [s/he] was fairly steady on [his/her] feet, but became more unsteady as the shift progressed. No falls this shift. No limping or signs and symptoms of pain noted from fall yesterday. Unable to obtain 2245 [10:45 PM] vitals from elder d/t [due to] [his/her] constant activity. By 2345 [11:45 PM] elder laid [him/herself] into bed, and has been resting quietly there ever since..." d. Review of a progress note dated 3/9/35 and timed 5:45 AM showed "Elder generally very restless and wakeful this [night]. [S/He] slept on and off for one to two hours, but then would sit up on side of bed, or get up and pace around a bit. Generally preoccupied [him/herself] with moving chairs, at one point threw a pillow into the kitchen, or rearranging [his/her] blankets. PRN Haldol was given at about 2045 [8:45 PM], it was ineffective. [His/her] muscular coordination seemed impaired, [s/he] was more unsteady on [his/her] feet, and [his/her] speech seemed more slurred than before. No agitation or aggressiveness noted this shift. At this time sitting on bedside and trying to put on [his/her] jacket like they were pants..." e. Review of a progress noted dated 3/7/25 and timed 1:10 AM showed "this elder has continued to pace and touch anything that catches [his/her] eye. [S/He] often stops whenever there is a change in design on the	F 725	Coverage Enhancement: a. Action: Additional staff will be assigned to provide dedicated support for the resident with severe dementia. b. Implementation: immediate implementation of a 1:1 dedicated staff member, starting on 4/2/2025. c. Responsibility: SMH House Supervisor and DON to coordinate daily assignments and adjust as needed. 2. Dementia Care Training: a. Action: Initiate training program to ensure staff are able to manage behaviors and care demands associated with severe dementia while maintaining good time management and promoting efficient and effective care for all elders within each dynamic cottage. b. Implementation: Begin training sessions and develop ongoing and continuous competency curriculum. c. Timeline: Training initiated 4/3/2025. Ongoing curriculum to be assigned to direct care staff by 4/18/2025. d. Responsibility: DON or competent designee. Monitoring/Sustainment: 1. Daily audit to be conducted for compliance with 1:1 assignment while maintaining cores staffing 2. Audit findings and outcome review will be reported to QAA committee monthly. 3. Daily monitoring of delayed and missed tasks. Goal of 90% completion per shift. Outcomes to be reported to QAA committee monthly.	

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F 725	Continued From page 17 carpeted floor to touch and scratch at the seams of the squares. [S/He] also "picks up" non-existent items from the floor and holds the items until [s/he] sees someone to give it to..." f. Review of a progress note dated 3/4/25 and timed 11:03 PM showed "Elder has been very restless so far this shift, pacing up and down hallway, trying to climb up onto kitchen island counter, moving chairs around, etc. No real agitation noted, although [s/he] didn't like it when [s/he] was redirected from going outside. Occasionally [s/he] verbalizes toward staff, but speech comes out as hushed whispers, and is mostly incomprehensible. PRN Haldol given at 2115 [9:15 PM], no beneficial effects noted until about an hour later. Elder is resting in [his/her] bed with eyes closed at this time and appears to be settled in for this noc, but will continue to monitor..." g. Review of a progress note dated 2/27/25 and timed 3:25 PM showed "Elder wandering cottage. Grabbing and trying to move objects: (table, chairs, trim on wall, closed/locked doors), touching other elders, very unsteady. Difficult to redirect. High risk for falls. Very frequent observation by staff. Elder refused breakfast and ate 25-50% of lunch. Drank small amounts of water..." h. Review of a progress note dated 2/25/25 and timed 11:30 AM showed "This nurse went to founder's house to fax something and when I was leaving out the front door the elder was right there. The two-Watt CNAs were just then running across the street. Elder was aggressively trying to get into founders with founder's family members having to use the back door to get in. Several attempts were made to redirect the elder back to Watt house, but this nurse was shoved by the elder. Another nurse (male) came to help and	F 725	Compliance Date: 4/18/25	

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F 725	Continued From page 18	F 725		

grabbed a wheelchair in hopes to get [him/her] to sit in it. After about 30 minutes the nurse and CNA were able to direct [him/her] into the back door of Watt. [S/He] was still agitated so this nurse gave [him/her] a PRN Haldol shot. The elder was trying to get into other residents' rooms. Daughter and DON were notified of current behaviors. Daughter mentioned to call her back if the PRN didn't help. Earlier in the morning, elder also tried to have a bowel movement on a recliner in the living room. CNA got him sat on the toilet and then [s/he] proceeded to stand back up and have a BM on the floor and spreading it with [his/her] foot."

i. Interview with the resident representative on 3/11/25 at 1:13 PM revealed she did not feel the facility had adequate staff to provide the care the resident required.

2. Interview with resident #7 on 3/11/25 at 11:15 AM revealed resident #20 had severe dementia and required a significant amount of staff's time. Further, the resident revealed staff did not have time to assist other residents in the cottage due to insufficient staff and resident #20's required needs.

3. Review of the posted staff schedule in the Watt cottage on 3/12/25 at 3:16 PM showed there was 1 CNA, a patient care tech, and an RN working in the cottage at that time.

4. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the Watt Cottage should have a 1 to 1 staff member for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. The patient care tech revealed she was currently in a CNA

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F 725	Continued From page 19 program; however, she had not completed the course. She revealed she had worked at the facility for 5 days and on day 2 when they did not have enough staff for the cottage, she was told to provide resident care such as perineal care and transfers. The patient care tech revealed on 3/10/25 she was told she was not allowed to perform resident care due to the survey. Further interview confirmed at that time there was 1 CNA, the RN, and the patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors.	F 725		
F 729 SS=C	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.	F 729		4/16/25

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F 729	Continued From page 20 §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview, the facility failed to ensure the CNA abuse registry was checked prior to resident contact for 4 of 4 CNA files (#6, #7, #8, #9) reviewed. The census was 28. The findings were: 1. Review of the employee filed for CNA #6 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 2. Review of the employee filed for CNA #7 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 3. Review of the employee filed for CNA #8 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact. 4. Review of the employee filed for CNA #9 showed the CNA had an active Wyoming certification and there was no evidence the abuse registry was checked prior to resident contact.	F 729	Deficiency Identified: SGH was found to have deficient practice related to F729 Nurse Aide Registry Verification, Retraining. The facility failed to ensure the C.N.A. abuse registry was checked prior to resident contact. Root Cause Analysis: SMH HR previously supported only inpatient and hospital-related operations with pre-employment verification requirements that are different from long term care. HR process included verification of CNA license, review of background check and completion of WY DFS Central Registry. Including C.N.A. abuse registry was not a known practice. Residents at Risk: Potential risk to all residents. Corrective Actions: 1. All SGH CNAs are primary source verified on the Nurse Aide Registry, or if applicable, HLS/CNA-109 forms are submitted to WY Health Care Licensing	

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F 729	Continued From page 21 5. Interview with human resources #1 and human resources #2 on 3/13/25 at 12:39 PM revealed the facility only checked for abuse through the department of family services and did not check the state CNA abuse registry. Further interview revealed they were not aware CNA abuse registry needed to be checked prior to resident contact.	F 729	and Surveys by 3/31/2025. 2. By 4/8/2025 HR will primary source any CNAs who have worked in other states as a CNA. 3. By 4/9/2025 HR will upload all primary sourced verifications from the Nurse Aide Registry to the employees personnel files. 4. By 4/11/2025 HR will add the Abuse Registry requirement to the SGH CNA job description(s). 5. By 4/11/2025 HR will update standard work with additional Nurse Aide Registry Verification requirement for newly hired, transfers, promotions, or secondary position/floats to CNA at SGH. 6. By 4/16/2025, which is the next scheduled Policy & Procedure Committee meeting, revise the SMH Hiring Policy to include Nurse Aide Registry Verification for all newly hired CNAs throughout the organization. Monitoring/Sustainment: HR currently has quarterly personnel file audit processes in place. HR will add the Nurse Aide Abuse Registry to the list of items reviewed and monitored in the audits. HR is also adding a Nurse Aide Registry line item to electronic talent profiles, so auditing can be completed electronically. Compliance Date: 4/16/2025 Responsible Person(s): SMH Human Resources Department	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3)	F 744		4/18/25

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GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 22 §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident representative and staff interview, the facility failed to ensure residents with dementia received the appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 4 residents (#20) reviewed for dementia care. The findings were: 1. Review of the annual MDS assessment dated 1/11/25 showed resident #20 had a BIMS score of 0 out of 15, which indicated severe cognitive impairment, and diagnoses which included dementia. Review of the resident's care plan last revised on 12/18/24 showed "I enjoy 1:1 time with staff. I like to talk about elk hunting, cars, and motors. I like going for strolls outside..." Further review showed "I may have behaviors of being verbally mean or getting agitated r/t [related to]dementia" and "I may wander or try to leave my cottage r/t History of attempts to leave facility unattended." The following concerns were identified: a. Observation in the Watt cottage on 3/12/25 from 1:34 PM to 4:53 PM showed the resident independently ambulated throughout the cottage. The resident occupied the common area and his/her room with intermittent staff redirection. Observation at 4:57 PM showed the resident was attempted to exit the facility into the courtyard. RN #1 attempted to redirect the resident and held the door closed until the resident ambulated away.	F 744	Plan of Correction for F744: Treatment/Services for Dementia Deficiency Description: SGH was found to have deficient practices related to F744 Treatment/Services for Dementia. The facility failed to ensure residents with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. During the survey, a resident with dementia was observed attempting to exit the facility and other residents becoming upset when the dementia resident approached them. In addition, the resident□s family expressed concerns that staff lacked patience and needed more dementia-specific training. Root Cause: The root cause of this deficiency is twofold: " Inadequate Individualized Care Planning: The current dementia care plan did not sufficiently address the resident□s behavioral challenges, including tendencies to wander or exit seeking, nor did it include strategies to minimize disruptive interactions with other residents.	

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F 744	Continued From page 23 Interview with the RN at that time revealed the cottage needed a 1 to 1 staff member to redirect the resident. Observation at 4:59 PM showed the resident ambulated over to the table near resident #7. Resident #7 became visually upset and asked staff to get the resident away from him/her. Resident #20 was redirected by CNA #5 to sit in arm chair near the resident's room. Further observation showed Domino's was performed in the cottage from 1:34 PM to 1:58 PM which 3 residents from the cottage, which did not include resident #20, and 1 resident from another cottage attended. Further observation showed no additional activities were performed in the cottage. b. Review of a progress note dated 3/10/25 and timed 3:47 AM showed "Elder was very restless last evening, and at times even agitated and combative. He took [his/her] medications mixed in ice cream, but no effect noted. In earlier part of shift [s/he] was fairly steady on [his/her] feet, but became more unsteady as the shift progressed. No falls this shift. No limping or signs and symptoms of pain noted from fall yesterday. Unable to obtain 2245 vitals from elder d/t [due to] [his/her] constant activity. By 2345 [11:45 PM] elder laid [him/herself] into bed, and has been resting quietly there ever since..." c. Review of a progress note dated 3/9/35 and timed 5:45 AM showed "Elder generally very restless and wakeful this [night]. [S/He] slept on and off for one to two hours, but then would sit up on side of bed, or get up and pace around a bit. Generally preoccupied [him/herself with moving chairs, at one point threw a pillow into the kitchen, or rearranging [his/her] blankets. PRN Haldol was given at about 2045 [8:45 PM], it was ineffective. [His/her] muscular coordination seemed impaired, [s/he] was more unsteady on [his/her] feet, and	F 744	" Insufficient Staff Training: There was a lack of comprehensive, ongoing dementia care training for staff. This resulted in inconsistent implementation of best practices for managing dementia behaviors, leading to staff feeling unprepared to de-escalate situations and manage high-needs residents effectively. Residents Affected: Because dementia is a dynamic disease process and the Sheridan Green House is a community living situation, all elders residing here may be impacted by dementia either directly or indirectly. Corrective Actions: 1. Immediate Safety Measures and Supervision Enhancements for cottage most impacted: a. Action: Review and adjust the current care assignment for the high-risk dementia resident. b. Implementation: Effective immediately, designated staff will be assigned to provide 1:1 supervision and monitoring. This will be recorded at the point of care through behavioral health documentation. This will enhance safety during exit seeking behaviors and enhance supervision of any interactions with other elders. c. Timeline: Initiated on 4/2/2025 d. Accountability: The DON will implement daily staff assignments to ensure adequate oversight. 2. Individualized Dementia Care Plan Revision:	

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F 744	Continued From page 24 [his/her] speech seemed more slurred than before. No agitation or aggressiveness noted this shift. At this time sitting on bedside and trying to put on [his/her] jacket like they were pants..." d. Review of a progress noted dated 3/7/25 and timed 1:10 AM showed "this elder has continued to pace and touch anything that catches his eye. [S/He] often stops whenever there is a change in design on the carpeted floor to touch and scratch at the seams of the squares. [S/He] also "picks up" non-existent items from the floor and holds the items until [s/he] sees someone to give it to..." e. Review of a progress note dated 3/4/25 and timed 11:03 PM showed "Elder has been very restless so far this shift, pacing up and down hallway, trying to climb up onto kitchen island counter, moving chairs around, etc. No real agitation noted, although [s/he] didn't like it when [s/he] was redirected from going outside. Occasionally [s/he] verbalizes toward staff, but speech comes out as hushed whispers, and is mostly incomprehensible. PRN Haldol given at 2115 [9:15 PM], no beneficial effects noted until about an hour later. Elder is resting in [his/her] bed with eyes closed at this time and appears to be settled in for this [night], but will continue to monitor..." f. Review of a progress note dated 2/27/25 and timed 3:25 PM showed "Elder wandering cottage. Grabbing and trying to move objects: (table, chairs, trim on wall, closed/locked doors), touching other elders, very unsteady. Difficult to redirect. High risk for falls. Very frequent observation by staff. Elder refused breakfast and ate 25-50% of lunch. Drank small amounts of water..." g. Review of a progress note dated 2/25/25 and timed 11:30 AM showed "This nurse went to	F 744	a. Action: Review and revise care plan interventions to ensure accuracy. b. Implementation: Conduct a comprehensive reassessment of the resident's behavioral needs and update the individualized care plan to include specific interventions to enhance safety of the resident through direct observation and engagement; and strategies to manage and redirect disruptive behavior when the resident interacts with others. Evaluation to be completed by a behavioral health professional for medication review and adjustment recommendations. c. Timeline: By 4/18/2025. d. Accountability: DON and primary care provider and/or Medical Director 3. Enhanced Dementia Training Program: a. Action: Develop and implement an ongoing, comprehensive dementia training program for all staff. b. Implementation: i. Initial Training: Initiate immediate training sessions for all staff, focusing on effective communication techniques, approach, de-escalation strategies, and patient-centered dementia care. ii. Ongoing Education: Schedule quarterly curriculum including in-services, online courses, articles, etc. to reinforce training concepts and update staff on new best practices. c. Timeline: initiated 4/3/2025. Ongoing curriculum to be assigned to direct care staff by 4/18/2025. d. Accountability: The DON will	

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F 744	Continued From page 25 founder's house to fax something and when I was leaving out the front door the elder was right there. The two-Watt CNAs were just then running across the street. Elder was aggressively trying to get into founders with founder's family members having to use the back door to get in. Several attempts were made to redirect the elder back to Watt house, but this nurse was shoved by the elder. Another nurse (male) came to help and grabbed a wheelchair in hopes to get [him/her] to sit in it. After about 30 minutes the nurse and CNA were able to direct [him/her] into the back door of Watt. [S/He] was still agitated so this nurse gave [him/her] a PRN Haldol shot. The elder was trying to get into other residents' rooms. Daughter and DON were notified of current behaviors. Daughter mentioned to call her back if the PRN didn't help. Earlier in the morning, elder also tried to have a bowel movement on a recliner in the living room. CNA got him sat on the toilet and then [s/he] proceeded to stand back up and have a BM on the floor and spreading it with [his/her] foot." h. Interview with the resident representative on 3/11/25 at 1:13 PM revealed the facility did not engage the resident in activities and staff could be more patient with the resident. The representative revealed staff approach with the resident could be better and it did not seem like staff were trained on dementia care as they did not allow the resident time to process requests or reapproach when the resident refused care. i. Interview with patient care tech #1 and RN #1 on 3/12/25 at 1:38 PM revealed the Watt Cottage should have a 1 to 1 for resident #20 and staff were unable to perform showers and other household duties, including activities which they were responsible for. Further interview revealed at that time there was 1 CNA, the RN, and the	F 744	coordinate training sessions for all staff. 4. Environmental Modifications for Watt cottage: a. Action: Evaluate and modify the physical environment to enhance safety and reduce triggers that may lead to resident agitation b. Implementations: Staff and cottage members will be educated on importance of maintaining a calm and quiet environment by reducing loud noises and environmental stimulation such as large groups in the cottage. Rounding throughout the cottages will occur multiple times a day by DON and other leadership with immediate corrective action and re-education to occur when necessary. Rounding log will be kept which will include time of day, observation and any environmental recommendations made. c. Timeline: Education regarding initiated 4/3/2025. Daily rounding will be implemented by 4/14/2025 Monitoring/Sustainment: Establish monthly care plan audits for the next 6 months to review care plan adherence; incident report monitoring for reduction in reported incidents related to escalated or unsafe behaviors; and staff performance related to direct dementia care and environmental management. This will be reported to QAA committee. Use audit data and resident outcome measures (e.g., exit seeking, aggression, complaints) to evaluate the impact of the corrective actions.	

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F 744	Continued From page 26 patient care tech on shift due to another CNA not showing up for the shift as scheduled and resident #20 was difficult to manage due to his/her behaviors. j. Interview with LPN #1 and CNA #2 on 3/12/25 at 2:44 PM revealed the activities director almost never came to the houses to do activities with the residents. The interview further revealed they don't do bingo anymore, and they used to do that a lot. The previous activities director used to frequently come around and do 1:1 activities like playing a game or doing crafts. Activities and 1:1 time were very helpful for the residents in Watt and Founders cottages who wander. They really benefited from the 1:1 time and were a lot more calm and less likely to wander as a result.	F 744	Compliance Date: 4/18/25	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		4/18/25

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F 757	Continued From page 27 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure residents' drug regimen was free of unnecessary drugs for 1 of 6 sample residents (#26) reviewed for unnecessary medications. The findings were: 1. Review of the physician orders for resident #26 showed the resident had an order for Cephalexin 250 milligrams (mg) 1 tablet by mouth one time a day for infection management which was ordered on 9/27/24 and didn't have a stop date. Review of a hospital "discharge note-physician" 9/26/24 showed the discharge plan indicated the resident had "recurrent infection" with no current symptoms and Cephalexin 250 mg was ordered daily for prophylaxis. Further review showed no evidence a physician rationale was provided for long-term antibiotic use. 2. Interview with the DON and administrator on 3/13/25 at 10:04 AM confirmed the physician had not provided rationale for the long-term use of the antibiotic. 3. Review of the policy titled "Antibiotic Stewardship" last revised on 8/20/23 showed "...The Antibiotic Stewardship Committee Will: 1. Support and promote antibiotic use protocols which include:..b. Therapeutic decisions regarding antibiotic prescriptions based on evidence (e.g., guidelines and consensus statements from clinical and academic societies) that is appropriate for the care of long-term facility	F 757	Plan of Correction for F757 □ Drug Regimen Free of Unnecessary Drugs Deficiency Description: SGH was found to have deficient practices related to F757 Drug Regimen Free of Unnecessary Drugs. The facility failed to ensure residents□ drug regimen was free of unnecessary drugs. It was observed that a resident was prescribed an antibiotic with no documented physician rationale supporting long-term use. Additionally, no Antibiotic Stewardship Committee is in place to ensure that antibiotic use protocols are appropriate for long-term care facility residents. Root Cause: The deficiency resulted from lack of consistent processes regarding medication regimen review processes. Compounding the issue is a lack of a formal antibiotic stewardship program. Residents at Risk: Drug Regimen review processes are expected to be completed for all residents, subsequently all residents are at risk. Corrective Actions: 1. Drug Regimen Review process establishment:	

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F 757	Continued From page 28 residents..."	F 757	a. Action: Standard Work will be written for the Drug Regimen Review process b. Implementation: Standard work will include roles and responsibilities of the pharmacist, the nursing staff, the primary provider and/or the Medical Director. c. Timeline: By 4/18/25 d. Responsibility: DON, Administrator, consulting pharmacist 2. Drug Regimen Review, facility wide: a. Action: All residents will have a current drug regimen review conducted b. Implementation: All charts will be audited for current drug regimen review. For charts that do not have current review, pharmacist will conduct a review. Facility nursing and medical teams will follow newly established standard work to ensure medication regimens are free from unnecessary medications. c. Timeline: By 4/18/25 d. Responsibility: Pharmacist, DON, nursing staff, medical clinicians 3. Resident Review and Documentation a. Action: Affected resident medication review will be conducted b. Implementation: The attending physician, in collaboration with the pharmacist, will reassess the resident□s clinical status and document a clear, evidence-based rationale for any antibiotic use. If the long-term use is not clinically justified, the regimen will be promptly modified or discontinued. c. Timeline: By 4/18/25 d. Accountability: DON, Administrator and attending physician.	

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F 757	Continued From page 29	F 757	4. Establish an Antibiotic Stewardship Committee: a. Action: Form a multidisciplinary Antibiotic Stewardship Committee. b. Implementation: At minimum, the committee should include the Medical Director or designee, Consulting Pharmacist and the Director of Nursing. The committee will be responsible for reviewing all antibiotic use, establishing protocols per regulatory guidelines, monitoring prescribing patterns, and ensuring compliance with evidence-based guidelines. c. Timeline: By 4/18/25 d. Accountability: Facility Administrator, DON and Medical Director. Monitoring/Sustainment: 1. Results, intervention and outcomes of facility wide drug regimen review will be reported to the QAA committee by DON at first QAA meeting after review complete. 2. Once a baseline drug regimen review is conducted, process will ensure that this is completed monthly and as needed. Compliance with process will be monitored by DON and reported to the QAA committee. Compliance Date: 4/18/25	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		4/18/25

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F 804	Continued From page 30 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and recipe review, the facility failed to ensure palatable food was served to 1 of 4 resident cottages (Founders). The cottage census was 9. The findings were: 1. Observation on 3/12/25 at 12:06 PM showed the lunch meal was "Creamy Chicken and Rice Soup;" however, the soup appeared to have a thick texture with no visible fluid similar to clay. Interview with resident #6 at that time revealed the flavor was "ok;" however, the soup was supposed to be creamy and it was too thick to eat. Interview with resident #19 at that time revealed s/he did not want to discuss the meal because there was "nothing good to say." 2. Interview with the dietitian on 3/12/25 at 4:06 PM confirmed the soup prepared for lunch was thicker than it should have been. She revealed the staff member who prepped the meal the previous night did not prepare it correctly and the dietitian had added broth to the recipe following the meal for future servings. Further interview confirmed there should have been broth in the soup. 3. Review of the recipe for "Creamy Chicken Rice Soup" a picture of the prepared meal which had visible liquid broth.	F 804	Plan of Correction F804 □ Nutritive Value/Appearance, Palatable/Preferred Temp Deficiency Identified: SGH was found to have deficient practices related to F804 Nutritive Value/Appearance, Palatable/Preferred Temp. The facility failed to ensure palatable food was served. Root Cause Analysis: Lack of quality assurance process in real time to ensure food is consistent with the expected outcome and palatable at the time of serve out. Lack of training to ensure anyone cooking is able to identify and correct when a recipe is not turning out as expected. Residents at Risk: Food is served in each cottage, all elders are at risk. Corrective Actions: 1. Dietary manager will audit meals and meal prep in real time to ensure appropriate skills and techniques are utilized and correction are made to ensure meal outcomes are palatable a. Tool to be developed to record observations and corrections made b. Data collected will be reviewed	

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F 804	Continued From page 31	F 804	monthly to inform and update culinary training schedule and ongoing skills and competency schedule c. Findings and adjustments will be reported to QAA by Dietary Manager, monthly d. Monitoring to begin by 4/18/25 2. Quality Feedback from elders and assembly of Food Quality Committee a. Dietary manager will design tool to capture feedback about palatability of food at time of service, from the elders, with the assistance of household staff b. Feedback will be collected at every lunch and supper meal for 30 days utilizing the standardized tool c. A group of elders will be recruited to assemble weekly to review audit findings and make recommendations for changes to recipes or menus. d. After 30 days, Food Quality Committee will determine next steps for the committee and quality feedback monitoring. e. Responsibility: Dietary Manager and Administrator or designee f. Monitoring to be begin by 4/18/25 Monitoring/Sustainment: Dietary manager will collect observation and feedback tools daily and weekly and report to QAA committee monthly Administrator will monitor for 90% compliance with process/data collection within 30 days. Food Quality Committee will determine	

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F 804	Continued From page 32	F 804	future steps for monitoring quality after 30 days of daily feedback and weekly meetings. Compliance Date: Process fully implemented by 4/18/25	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure an antibiotic stewardship program was implemented. The census was 28. The findings were: 1. Review of the physician orders for resident #26 showed the resident had an order for Cephalexin 250 milligrams (mg) 1 tablet by mouth one time a day for infection management which was ordered on 9/27/24 and didn't have a stop date. Review of a hospital "discharge note-physician" 9/26/24 showed the discharge plan indicated the resident had "recurrent infection" with no current symptoms and Cephalexin 250 mg was ordered daily for prophylaxis. Further review showed no evidence a physician rationale was provided for long-term antibiotic use. Interview with the DON	F 881	Plan of Correction for F881 Antibiotic Stewardship Program Deficiency Description: SGH was found to have deficient practices related to F881 Antibiotic Stewardship Program. The facility failed to ensure an antibiotic stewardship program was implemented. It was observed that a resident was prescribed an antibiotic with no documented physician rationale supporting long-term use. No Antibiotic Stewardship Committee is in place. Root Cause: There is no antibiotic stewardship committee in place to ensure that antibiotic use protocols are appropriate for	4/18/25

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GREEN HOUSE LIVING FOR SHERIDAN	2311 SHIRLEY COVE SHERIDAN, WY 82801

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F 881	Continued From page 33 and administrator on 3/13/25 at 10:04 AM confirmed the physician had not provided rationale for the long-term use of the antibiotic and the facility had not implemented an antibiotic stewardship program to review antibiotic usage. 2. Review of the policy titled "Antibiotic Stewardship" last revised on 8/20/23 showed "...Antimicrobial Stewardship is a coordinated program that appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms. The Infection Control Committee and Infection Preventionist shall take an active and effective role in monitoring the use of antibiotics at GHLS..."	F 881	long-term care facility residents. Residents at Risk: Antibiotic/Antimicrobial Stewardship improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms, therefore all residents are at risk in its absence. Corrective Actions: 1. Establish an Antibiotic Stewardship Committee: a. Action: Form a multidisciplinary Antibiotic Stewardship Committee. b. Implementation: At minimum, the committee should include the Medical Director or designee, Consulting Pharmacist and the Director of Nursing. The committee will be responsible for reviewing all antibiotic use, establishing protocols per regulatory guidelines, monitoring prescribing patterns, and ensuring compliance with evidence-based guidelines. c. Timeline: By 4/18/2025 d. Accountability: Facility Administrator, DON and Medical Director. 2. Develop and Implement Antibiotic Use Protocols: a. Action: Develop written protocols for antibiotic prescribing and review. b. Implementation: The Antibiotic Stewardship Committee will develop protocols based on current best practices and guidelines (e.g., from the CDC and professional geriatric care organizations) including criteria for initiating, continuing,	

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F 881	Continued From page 34	F 881	and discontinuing antibiotic therapy; requirements for documentation of physician rationale for long-term antibiotic use; and regular review intervals for antibiotic regimens. c. Timeline: First meeting will be held within 14 days of committee assembly d. Accountability: Antibiotic Stewardship Committee, DON, Administrator 3. Staff Training and Education a. Action: Conduct comprehensive training for all nursing staff on antibiotic stewardship committee responsibility and the importance of appropriate antibiotic use. b. Implementation: Training will be delivered through in-service sessions and documented in the facility□s training records. c. Timeline: By 4/18/2025 d. Accountability: Director of Nursing and/or appointed designee. Monitoring/Sustainment: All antibiotics prescribed will be reviewed for compliance with the established protocols and documentation through resident record review. Goal for 90% compliance within 90 days of establishment. The Antibiotic Stewardship Committee will review antibiotic prescribing patterns monthly. A report summarizing compliance, identified issues, and corrective actions will be presented at QAA by DON or designee. Compliance Date: 4/18/2025	

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F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to ensure a qualified infection preventionist was designated. The census was 28. The findings were: Interview with the facility administrator on 3/10/25 at 3:28 PM revealed the infection preventionist position was open and she was keeping up with the program with assistance from the hospital. Further interview confirmed there was nobody on staff who had completed specialized training in infection prevention and control.	F 882	Deficiency Description: SGH was found to have deficient practices related to F882 Infection Preventionist Qualifications/Role. Facility failed to designate a qualified Infection Preventionist (IP) for the Infection Prevention and Control Program (IPCP). No staff member had completed the required specialized training in infection prevention and control. Root Cause: The deficiency resulted from the absence of qualified individual with specialized training to oversee the IPCP. Residents at Risk:	4/18/25

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F 882	Continued From page 36	F 882	The Infection preventionist role is intended to enhance preventive measures in the spread of infectious processes. Without this role, all residents are at an increased risk for infection. Corrective Actions: 1. Designation of a Qualified Infection Preventionist: a. Action: Designate one or more staff members to serve as the facility□s infection preventionist(s). b. Implementation: By 4/18/2025, identify and designate a staff member who will assume the role of infection preventionist. c. Responsibility: Director of Nursing (DON) in collaboration with the Administrator. 2. Specialized Training and Competency: a. Action: Ensure that the designated infection preventionist completes specialized training in infection prevention and control. b. Implementation: Enroll the designated infection preventionist in an approved training program (e.g., APIC□s training programs, CDC modules, or state-specific infection prevention courses). Document training completion in the staff member□s personnel file. c. Timeline: Training to be identified and enrolled by 4/18/2025 d. Responsibility: DON and Administrator. 3. Integration with the Infection	

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F 882	Continued From page 37	F 882	Prevention and Control Program: a. Action: Integrate the infection preventionist into the facility□s IPCP and QAPI initiatives. b. Implementation: The infection preventionist will begin participating in the facility monthly QAA meetings. Develop a process for regular monitoring of infection control practices to include audits conducted monthly to ensure compliance with infection control practices and compliance with the IPCP. Provide quarterly reports summarizing infection trends, training activities, and any identified areas for improvement. Any non-compliance or issues will be addressed promptly through corrective action plans. c. Timeline: Integration to begin immediately following training completion, with monthly meetings. Monthly audits, with quarterly reporting to QAA committee. d. Responsibility: Infection Preventionist and DON. Monitoring/Sustainment: Key Performance Indicators: " Successful designation and documentation of a qualified infection preventionist. " Completion of specialized training and competency assessments. " Regular participation in IPCP and QAA meetings. " Monthly audit results demonstrating adherence to infection prevention practices. " Review Process: The effectiveness of these corrective actions will be reviewed	

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F 882	Continued From page 38	F 882	monthly by the QAA committee and reported to facility leadership, with adjustments made as necessary to ensure ongoing compliance. Timeline Summary: By 4/18/25: Designate the infection preventionist and develop role requirements; enroll infection preventionist in appropriate training. Ongoing: Conduct monthly audits and quarterly reviews to ensure sustained compliance and effectiveness.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		4/18/25

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F 883	Continued From page 39 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and policy and procedure review, the facility failed to document if residents were educated about the benefits and potential side effects of the influenza and pneumococcal immunizations and if residents received the immunizations for 4 of 6 sample residents (#12, #14, #24, #28) reviewed	F 883	F883 Influenza, Pneumococcal, and COVID-19 Immunizations Deficiency Overview: SGH was found to have deficient practices related to F883 Influenza, Pneumococcal, and COVID-19	

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F 883	Continued From page 40 for immunization status. The findings were: 1. Review of the immunization records for resident #12 showed there was no evidence of education, offer, refusal or receipt of a current pneumococcal immunization. 2. Review of the immunization records for resident #14 showed there was no evidence of education, offer, refusal or receipt of an annual influenza, current COVID-19, or current pneumococcal immunization. 3. Review of the immunization records for resident #24 showed there was no evidence of education, offer, refusal or receipt of an annual influenza or current pneumococcal immunization. 4. Review of the immunization records for resident #28 showed there was no evidence of education, offer, refusal or receipt of an annual influenza, current COVID-19, or current pneumococcal immunization. 5. Interview with the administrator and director of nursing on 3/13/25 at 9:35 AM revealed the facility should offer and encouraged all immunizations. Further interview confirmed the facility did not have evidence the immunizations were offered or provided for resident #12, #14, #24 and #28. 6. Review of facility policy titled "Vaccination of Elders Policy" last updated 3/3/22 showed "...Prior to receiving vaccinations, the elder or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented	F 883	Immunizations. The facility failed to document if residents were educated about the benefits and potential side effects of influenza and pneumococcal immunizations as well as for not documenting the offer, refusal, or receipt of these immunizations. Root Cause Analysis: The root cause of this deficiency has been identified as a multi-faceted process failure: 1. Staff Training Gaps: Staff are not uniformly trained on the updated immunization process and documentation requirements, leading to inconsistent practices. This includes standardized resident education on immunizations and completed documentation including offer, refusal, or receipt of influenza, pneumococcal, and COVID-19 immunizations. 2. Lack of a regulatory Infection Prevention Program to offer oversite. Corrective Actions: 1. Process Revision a. Action: Update standard work to clearly define the process for providing education and documenting all immunization-related activities. b. Key Requirements to Include: i. Mandatory education for all residents (and families, as applicable) on the benefits and potential side effects of influenza, pneumococcal, and COVID-19 immunizations. ii. Documentation of the immunization offer, residents acceptance or refusal,	

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F 883	Continued From page 41 in the elder's medical record... If vaccinations are refused, the refusal shall be documented in the elder's medical record. If the elder receives a vaccination, at least the following information shall be documented in the elder's medical record: a. Site of administration, b. Date of administration, c. Lot number of the vaccine, d. Expiration date, e. Name of person administering the vaccine..."	F 883	and, if administered, detailed vaccine information (site, date of administration, lot number, expiration date, and the name/credentials of the person administering the vaccine). c. Timeline: Complete and disseminate standard work by 4/18/25 d. Responsibility: Facility Administrator, Director of Nursing and IP. 2. Audit all records for current compliance a. Action: All resident records will be audited for documentation being up to date and accurate b. Implementation: 100% audit of records to be conducted by DON or designee to determine: i. Is immunization record up to date reflecting an accurate immunization history ii. Has each resident received or been offered the most current vaccination schedule c. Timeline: by 4/18/2025 d. Responsibility: DON or designee 3. Offer, provide, document receipt or declination of any vaccinations elders are currently eligible to receive a. Action: Implement standard work to ensure all elders currently eligible for up to date vaccinations receive education about offering and complete vaccination administration or declination with appropriate documentation b. Implement: DON will obtain education materials and vaccination from pharmacy. Nursing staff will offer, provide and	

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F 883	Continued From page 42	F 883		

document immunization offering and receipt per standard work.
c. Responsibility: Pharmacy, DON, nursing staff

4. Staff Training and Competency Assessment
a. Action: Provide training to all clinical staff on the updated immunization standard work, education procedures, and proper documentation.
b. Training Components:
i. Overview of the updated standard work and documentation requirements.
ii. Step-by-step demonstration of how to complete education, immunization administration or declination and documentation.
c. Timeline: By 4/18/2025
d. Responsibility: Director of Nursing or designee.

Monitoring/Sustainment
Conduct monthly audits of a random sample of resident medical records to verify the presence of complete immunization education and administration documentation after facility-wide audit for all immunizations has been completed. Review audit results during monthly QAA meetings. Initiate corrective action immediately for any deficiencies identified. Monthly audits to commence immediately, carried out by the DON and/or designee upon implementation and on-going.
100% of resident medical records will include documented evidence of immunization education, offer/refusal, and

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F 883	Continued From page 43	F 883	if applicable, administration details within 90 days. Timeline Summary: Develop and initiate standard work procedures and complete initial staff training by 4/18/2025. Monthly (for 6 months): Perform audits and review compliance in QAA meetings. Compliance Date: 4/18/25	