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Form Approved OMB
No. 0938-0391

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	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green House Living for Sheridan	2311 Shirley Cove Sheridan, WY 82801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37220 Based on medical record review, and elder and staff interview, the facility failed to have a system in place to ensure respiratory care was provided consistent with the elder's goals and preferences for 1 of 1 elder reviewed (#3) for respiratory care. The findings were: 1. Review of the 1/24/24 quarterly MDS assessment showed elder #3 had a BIMS score of 15 out of 15 (cognitively intact) and had a diagnosis which included an unspecified pulmonary disease such as asthma, chronic obstructive pulmonary disease, or chronic lung disease. The following concerns were identified: a. Interview on 3/19/24 at 8:21 AM with the elder revealed s/he had been having problems with his/her CPAP (continuous positive airway pressure) mask for approximately 3 months. The elder stated s/he had spoken with the former DON and nothing was done so s/he called the respiratory service company in [NAME] and was informed the DON had to make the inquiry. The elder stated the SW recently brought him/her a grievance form and s/he was going to submit it today. b. Review of a communication note, dated 2/26/24, showed LATE ENTRY .Elder had some concerns about [his/her] CPAP mask not fitting properly and causing [his/her] eyes to become red, dry, and irritated. Elder was frustrated that the concern was not being addressed. SW advised Elder to reach out to regional ombudsman if she felt she wasnot (sic) being heard. Elder also asked to call the CPAP POC. SW obtained the CPAP number from DON and shared it with Elder. Elder called and was told [s/he] can have a consult with a CPAP representative but [Green House] has to set it up. SW informed DON. 2. Interview with the current DON on 3/20/24 at 11:47 AM revealed the CPAP representative had been called on 3/19/24. The former DON had recently resigned and was unavailable.

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.

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on observation, review of medical records, staff job descriptions, facility incident reports, the payroll report, and the daily nursing staff postings, and elder and staff interview, the facility failed to ensure sufficient nursing staff to provide nursing and related services to assure elder safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of the elders. The census was 38. The findings were: Review of the Shahbaz Job Description showed the Shahbaz were responsible for the following: a. Recognize and respond to the needs of Elders and assure their safety at-all-times. b. Report changes in the Elder's condition to the RN's per change in condition protocols. c. Promptly observe, report and provide skin care and alert the presence of pressure areas to prevent decubitus as according to policy. d. Maintain occupied and unoccupied beds, to include changing bed linens, when necessary. e. Assist moving, positioning and transporting Elders into/from beds, chairs, bathtubs, wheelchairs, lifts, etc. f. Assist elders with personal care functions, including: bathing, dressing, grooming, dental and mouth care, hair and nail care, bowel and/or bladder care, and as-needed personal hygiene care. g. Assure that call notifications by the Elders are answered promptly and professionally. h. Assist in performing restorative and rehabilitative procedures as outlined by care plans. i. Obtain and record vital signs, such as temperature, pulse, respirations, weight, height, anatomical dimension and circumference, etc. j. Assist with the application of slings, elastic bandages, binders, etc., as directed. k. Facilitate and/or assist Elder daily range-of-motion exercises, as needed. l. Follow safety precautions to observe, monitor, intervene or report any unsafe conditions. m. Prepare and serve meals; kitchen and dining room clean-up after meals; provide snacks as requested consistent with the posted menu and stated preferences of the Elder. n. Launder Elder's clothing, linen and other articles, as needed. o. Perform routine housekeeping duties including cleaning Elder living areas and environment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	p. Perform other clinical support related duties, as requested. Related to [NAME] Cottage (Census = 7): 1. Review of the 1/11/24 admission MDS assessment showed elder #1 had a diagnosis of non-Alzheimer's dementia, a BIMS score of 4 out of 15 (indicating severe cognitive impairment), and was independent with bed mobility, transfers, and had the ability to walk at least 150 feet. Review of the resident's care plan, dated 1/26/24, showed I may wander or try to leave my cottage r/t History of attempts to leave facility unattended. The following concerns were identified: a. Review of a facility incident report, dated 2/3/24 and timed 9:20 AM, showed Shabaz reported to nurse that they found Elder outside the cottage trying to leave campus . b. Review of a facility incident report, dated 2/25/24 and timed 10:40 PM, showed .CNA called RN to come outside right away as [the elder] was trying to escape the compound & unable to redirect [elder]. Four staff showed up in front of the [NAME] building to try & get [the elder] to return .very angry and confused. [11:30 PM]-[the elder] managed to slip out the front door with soap dispenser . c. Review of a general progress note, dated 3/3/24 and timed 7:15 PM showed the Elder was in the common room watching television and spoke with the RN about walking tonight to pick up a gas can for tomorrow . (only 1 CNA present in house & giving a shower to another resident.) RN stayed within house to watch [the elder] closely with [his/her] past history of elopement till CNA was finished giving a shower. Observed [the elder] walking around & looking into the kitchen but also walking over to the exit doors. [The elder] asked nurse about the locks on the doors. On 3/1, back door found open by another resident & very sure it was [the elder] . d. Review of an incident report, dated 3/10/24 showed Shabhaz called this nurse to ask for help with Elder after elder struck shabhaz in the chest. Before nurse could arrive the shabhaz called again informing that the Elder had picked up a broom and was swinging it. The shabhaz got hit by the broom .The shabhaz was able to regain the broom from the elder and then called the Elder's daughter to calm the Elder down. This was effective. Immediate action taken showed This nurse went to the house the elder is staying in and sat with him/her ([the elder] was calm by this time [9 PM]). The elder's daughter arrived at 9:30 PM . e. Review of a Communication note dated 3/11/24 and timed 4:21 PM showed .SW also informed Elders daughter we will be sure to not schedule male Shahbaz in the cottage as it triggers Elder. SW clarified that there might be instances where a male might need to work in [NAME] due to staffing shortages. f. Review of a General Progress Note dated 3/17/24 and timed 3:58 AM showed The elder continues to roam throughout the facility and excited (sic) the facility twice between the hours of 2000 (8 PM) and 2100 (9 PM). g. Review of a General Progress Note, dated 3/18/24 and timed 12:32 AM showed This elder continues to wander throughout the unit. [The elder] becomes frustrated and attempts to break the sliding doors into the kitchen area and goes through any closed door. [The elder] has gone outside into the parking lot and into the fenced in area in the back . (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

h. Observation on 3/19/24 at 11:18 AM showed the elder was sitting in the common room of [NAME] cottage with no staff in the vicinity. The elder was observed to ambulate independently.

i. Review of the daily nurse postings showed on 2/3/24 the census was 3 with 2 CNAs and 1 nurse scheduled during the day shift; on 2/25/24 the census was 5 with 1 CNA and .5 nurse scheduled on the night shift; on 3/3/24 the census was 7 with 1 CNA and .5 nurse scheduled on the night shift; and on 3/17/24 the census was 7 with 1 CNA and .5 nurse scheduled on the night shift.

j. Review of the [NAME] call history report showed on 2/25/24 at 9:47 PM the elder departed his/her room at 9:48 PM, the door alarm at the lobby entrance triggered and was canceled at 9:52 PM; and at 9:52 PM an exit door alarm was triggered and was canceled at 11:08 PM.

k. Interview with on 3/19/24 at 10:19 AM with elder #4 revealed that elder #1 had behaviors and attempted to exit the cottage. Elder #4 stated often times the staff were not readily available and the other elders in the cottage felt like it was their duty to keep the elder #1 from leaving the cottage.

l. Interview with the DON on 3/20/24 at 11:47 AM revealed the [NAME] call system was launched at the beginning of March 2024 and the elder was going to be the first to be outfitted with the pendant which would monitor the elder's whereabouts. The DON was unsure how to interpret the [NAME] call history reports as they were still learning the system.

Related to [NAME] Cottage (Census = 10):

1. Review of the 12/30/23 quarterly MDS assessment for elder #5 showed the elder had a BIMS score of 6 out of 15 (indicating severe cognitive impairment) and wandered 1 to 3 days of the look-back period. Review of the elder's care plan, last revised on 6/29/23, showed the elder was independent with transfers and used a cane for walking. The following concerns were identified:

a. Review of an incident report, dated 2/13/24 and timed 5:26 AM, showed Elder exited facility and was brought back into [NAME] cottage by day shift shahbaz who came early. [The elder] did not fall and had [his/her] jacket on .Employee exit alarm shows it had been ringing for 3 minutes.

b. Review of an incident report, dated 3/2/24 and timed 9:40 PM, showed Elder was found outside ambulating on east side of Founder's cottage at around [6:30 PM] Further review showed the nurses that found the resident took him/her into Founder's cottage and then notified the shahbaz at [NAME]. The note section of the incident report showed somewhat tired after ambulating a great distance. [RN] states that [the elder] had walked past south side of cottage before turning northward on east side of cottage.

c. Review of the daily staff posting from 2/1/24 through 3/19/24 (47 days) showed the cottage was staffed during the day with 3 CNAs on 15 days, 2 CNAs on 15 days, 5 CNAs on 1 day, and 16 days were left blank. During the night shift the cottage was staffed with 2 CNAs on 16 days, 3 CNAs on 2 days, 1 CNA on 1 day, and 28 days were left blank.

Related to [NAME] Cottage (Census = 10):

(continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Observation on 3/19/24 at 11:18 AM showed 4 elders were sitting at the dining table in the common room in their wheelchairs. Activities assistant #1 and CNA #2 were in the kitchen area. The activity assistant left the cottage to obtain ice and upon her return began washing the dishes from the morning meal. CNA #1 returned to the cottage at 11:35 AM. At 11:39 AM the life enrichment coordinator entered the cottage and began assisting with the meal service. At 11:51 AM the maintenance director entered the cottage and began assisting with meal service. b. Observation on 3/19/24 at 11:23 AM showed elder #2 was sitting in his/her wheelchair accompanied by his/her representative. Interview with the elder's representative at that time revealed the elder had dementia and slept a lot. The representative stated he had been asking to have the elder transferred to a recliner for 1 and 1/2 hours with no response. The elder's representative was becoming upset with the staff using a raised voice when speaking. At 11:27 AM the elder's representative asked CNA #2 again to transfer the resident to a recliner. CNA #2 stated her care partner was on break and she was unable to transfer the elder by herself. The elder was transferred to the recliner at 11:41 AM and then at 12:16 PM was transferred back to his/her wheelchair and brought to the dining room table for the noon meal. c. Observation on 3/19/24 at 11:43 AM showed CNA #1 and CNA #2 entered elder #6's room and closed the door. The CNAs exited the room at 12:04 PM and brought the resident to the dining table for the noon meal. The nurse assigned to the cottage was observed to go in and out of the room two times from 11:43 AM to 12:04 PM. d. Interview with CNA #1 on 3/19/24 at 3:20 PM revealed the census of [NAME] Cottage was 10 with 2 independent elders, 2 elders which required toileting/transferring assistance, and 6 elders which were dependent on 2 staff members for assistance. Two elders required assistance with eating. The CNA stated there were days that there was not enough time to do all of the tasks they were responsible for. In addition, the CNA stated the mid-shift staff member called off, and administration stepped in to help, which was not typical. e. Interview with CNA #2 on 3/19/24 at 3:35 PM revealed mornings at the cottage were crazy and when the night shift CNAs did not do the preparation for the morning meal it put them behind. f. Interview with the life enrichment coordinator (LEC) on 3/19/24 at 4 PM revealed she thought 3 CNAs should be scheduled for [NAME] Cottage at all times due to the amount of time the CNAs needed to care for the elders. The LEC stated it took the CNAs at least 30 to 45 minutes to care for elder #2 at times. Further, the LEC stated she had obtained her CNA license; however, she only worked part-time at the facility. g. Review of the daily staff posting for [NAME] Cottage from 2/2/24 to 3/19/24 (47 days) showed the cottage was staffed during the day with 2 CNAs on 12 days; 3 CNAs on 22 days; 4 CNAs on 2 days; and 11 days were not documented. During the night shift the cottage was staffed with 2 CNAs on 36 days; 3 CNAs on 2 days; 4 CNAs on 1 day; and 8 days were not documented. Related to the general facility: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Interview with the SW on 3/19/24 at 2:31 PM revealed at the beginning of February nine CNAs submitted their resignations on the same day, citing an issue related to a member of the management team. Further, the SW stated the board of trustees were aware of the concern and an investigation was started. 2. Interview with the CEO on 3/20/24 at 12:03 PM confirmed 9 CNAs resigned giving two week's notice at the beginning of February. The CNAs had voiced a grievance with the board of trustees present. The board immediately placed the CNAs on administrative leave; not allowing them to fulfill the 2 week's notice. 3. Review of the payroll hours report provided by the facility showed the following concerns: a. CNA #3 worked from 5:56 AM to 4:15 PM with no lunch on 2/1/24 and then worked from 11:52 PM until 6:36 AM on 2/2/24 for a total of 17.06 hours. In addition, the CNA worked 58.48 hours the week of 2/4 to 2/10; 48.9 hours the week of 2/11 to 2/17; 52.25 hours from 2/18 to 2/24; 62.35 hours from 2/25 to 3/2; and 61.8 hours from 3/3 to 3/9. Interview with the CNA on 3/19/24 at 5:45 PM confirmed she worked a lot of hours and stated it takes its toll. b. CNA #4 worked 70.68 hours the week of 2/4 to 2/10; 37.03 hours the week of 2/11 to 2/17; 64.92 hours the week of 2/18 to 2/24; 49 hours the week of 2/25 to 3/2; and 39.76 hours the week of 3/3 to 3/9. c. CNA #1 worked 22 hours the week of 2/18 to 2/24; 24.92 hours the week of 2/25 to 3/2; 24.79 hours the week of 3/3 to 3/9; and 24.92 hours the week of 3/10 to 3/16. Interview with the CNA on 3/19/24 at 3:20 PM revealed she was agency staff. d. CNA #2 worked 56.44 hours the week of 3/3 to 3/9 and 61.83 hours the week of 3/10 to 3/16. Interview with CNA #2 on 3/19/24 at 3:35 PM revealed she had been employed by the facility since 3/2/24. 4. Interview with the human resource director (HRD) on 3/20/24 at 11:14 PM revealed the full-time CNAs normal working schedule included 36 hours one week with a mandatory 48 hours the following week. When the facility needed a shift staffed, a notice would be sent out electronically to the staff requesting volunteers. Further the HRD stated the facility currently had 2 agency staff and 3 full-time CNA openings. He stated the scheduling for CNA #1 was an error and she should have been scheduled for more than 2 shifts per week.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on review of the posted nurse staffing data and staff interview, the facility failed to ensure the posted 24/7 hour nursing staff included all required information. The census was 38. The findings were: 1. Review of the 2/1/24 to 3/18/24 daily nurse staffing information for Founders Cottage showed the following concerns: a. Review of 14 out of 47 days (2/11, 2/12, 2/13, 2/16, 2/17, 2/21, 2/22, 2/26, 2/27, 2/29, 3/1, 3/2, 3/6, 3/18) failed to include the elder census, the total number and actual hours worked by the CNAs, registered nurses, and the licensed practical nurses per shift. 2. Review of the 2/2/24 to 3/18/24 daily nurse staffing information for [NAME] Cottage showed the following concerns: a. Review of 14 out of 46 days (2/4, 2/5, 2/8, 2/11, 2/13, 2/17, 2/18, 3/3, 3/4, 3/5, 3/10, 3/16, 3/17, 3/18) failed to include the elder census, the total number and actual hours worked by the CNAs, registered nurses, and the licensed practical nurses per shift. 3. Review of the 2/1/24 to 3/18/24 daily nurse staffing information for [NAME] Cottage showed the following concerns: a. Review of 29 out of 47 days (2/2, 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/11, 2/12, 2/13, 2/14, 2/20, 2/21, 2/27, 2/28, 3/4, 3/5, 3/6, 3/8, 3/9, 3/10, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18) failed to include the elder census, the total number and actual hours worked by the CNAs, registered nurses, and the licensed practical nurses per shift. 4. Interview with the DON on 3/19/24 at 2:56 PM confirmed the daily nurse staffing data information posts were incomplete.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 37220 Based on review of the Wyoming Administrative Rules, Nursing Home Administrators, Chapter 2: Licensure Requirements, the facility assessment, the Wyoming Healthcare Facility Change Form, and staff and board of trustee interview, the facility failed to appoint a licensed, administrator as established by the Wyoming Board of Nursing Home Administrators. The census was 38. The findings were: 1. Review of the Wyoming Nursing Home Administrators Chapter 2 Rules, effective 12/19/19, showed Section 1. License Required. No individual shall perform any function specifically authorized for a Nursing Home Administrator nor function as a Nursing Home Administrator nor represent himself as a Nursing Home Administrator unless licensed by the Board. 2. Review of the Wyoming Department of Health Healthcare Facility Change in Personnel/E-mail Address Form, dated, 2/13/23, showed the CEO was named as the new Administrator/Director. The form did not include a Wyoming professional license number. 3. Review of the facility assessment, last updated on 1/29/24, showed Part 3: Facility Resources Needed to Provide Competent Support and Care for our Elder Population Every Day and During Emergencies Staff type 1.1 Outlined below are the type of staff members, other health care professionals, and medical practitioners that we have identified are needed to provide support and care for our elders. A CEO was listed as being on-staff; however, there was no evidence the facility employed a NHA. 4. The facility was unable to locate a job description for the CEO or NHA. 5. Interview with the CEO on 3/19/24 at 12:39 PM revealed her title was CEO and she did not have a license from the Wyoming Board of Nursing Home Administrators. 6. Interview with the president of the Board of Directors on 3/19/24 at 3 PM revealed the board had recently become aware of the regulation and was taking immediate action. Further, the president stated the CEO had been acting as the nursing home administrator since February of 2023.