

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Green House Living for Sheridan		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081</p> <p>Based on resident and staff interview, medical record review, and facility incident report review, the facility failed to ensure a safe functional environment in 3 of 4 cottages ([NAME], [NAME], Founders). The findings were:</p> <ol style="list-style-type: none"> Review of a facility incident report dated 3/29/24 and timed 7:30 AM showed staff entered the room of resident #1 to assist him/her out of bed. At that time, the room was extremely hot with a thermostat reading of 97 degrees Fahrenheit, despite being set to 71 degrees Fahrenheit. In addition, the resident was lethargic and flushed with red skin. Further review showed the resident had a temperature of 100.4 degrees Fahrenheit and was transferred to the hospital for intravenous rehydration and further evaluation. Review of a progress note dated 3/29/2024 and timed 12:07 PM showed the resident was ordered antibiotic therapy for suspected pneumonia during the hospital evaluation. Interview with resident #2 on 4/4/24 at 4:50 PM revealed the resident was previously located in the [NAME] cottage; however, s/he had to be moved after the heater in his/her room began to smoke. Further interview revealed the temperature was often cold when it should have been hot and hot when it should have been cold. Interview with RN #1 on 4/4/24 at 4:33 PM revealed both the [NAME] and [NAME] cottages were having heat/AC issues and administration was aware and was working on it. Interview with the maintenance director on 4/4/24 at 5:25 PM revealed the baseboard heat in the cottages had been shut off and central heat and air conditioning was used to regulate the cottage temperatures. She revealed an electrician was in room [ROOM NUMBER] this morning to test the bathroom fan and it was working properly; however, the facility had not identified the root cause of the increase in the room temperature and the resident was returned to the room after discharge from the hospital. The director had requested a temperature log for room [ROOM NUMBER] with timestamps from the vendor to evaluate the change in room temperature during that time frame. Further interview revealed there were previous concerns in the [NAME] cottage room [ROOM NUMBER], relay replaced in the baseboard heater and the resident was moved to another cottage because of smoke coming out of the heater and a smell which was reported about 2 weeks ago in the Founders cottage room [ROOM NUMBER] and the baseboard heat was shut off. She revealed the long term plan was to remove all 48 baseboard heaters and upgrade the HVAC system from a multi zone system to a split zone system. <p>(continued on next page)</p>

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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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Interview with the maintenance director on 4/4/24 at 6:01 PM confirmed the facility initially turned off the breaker to the heating lamp in resident #1's bathroom as they believed it was the source of the elevated temperature; however, an electrician assessed the heating lamp and was unable to find a malfunction. She confirmed the breaker was turned back on, the resident remained in the room, and the facility could not ensure a similar even with the resident's heating system would not occur.</p>		