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	11/19/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative and staff interview, facility incident review, and root cause analysis review, the facility failed to ensure adequate supervision to prevent accidents for 1 of 6 sample residents (#1) reviewed for incidents and accidents. This failure resulted in actual harm to resident #1. Corrective measures were implemented prior to the survey and compliance was determined to be met on 11/12/25 The findings were:1. Review of the admission MDS assessment dated [DATE] showed resident #1 had a brief interview for mental status score of 11 out 15, which indicated moderate cognitive impairment, and diagnoses which included progressive neurological conditions. Further review showed the resident used a walker for mobility and required partial/moderate assistance with upper and lower body dressing, personal hygiene, sit to stand transfers, toilet transfer, and walking 10 feet. The following concerns were identified:a. Review of a progress note dated 10/18/25 and timed 7:35 PM showed Note Text: Elder fall: RN entered [NAME] cottage after performing med pass for [NAME] cottage and CNA's [sic] reported elder fell in his bathroom. Elder reports [s/he] was sitting on the floor for a while before CNA found [him/her]. Elder reports getting off toilet then falling towards bathroom sink and hit [his/her] left forehead on object (elder not able to report what [s/he] hit head on). Left elbow abrasion as well. VS and neuro assessment initiated per facility protocol. Elder denies pain except when RN applied dressing to left forehead hematoma. Head wound has minimal to moderate serous drainage. Elder on Plavix. Elder assisted by RN/CNA (after musculoskeletal assessment for pain, injury and impaired ROM) to recliner w/o issue or complication. RN notified DON/Executive director at 0950 then called hospitalist at 1002 with SBAR. Hospitalist recommended EMS transport to ED for evaluation d/t [due to] head injury and elder on medication of Plavix. POA notified at 1000 and POA/Elder in agreement for EMS transport to SMH. EMS arrived and [NAME] cottage at approx 1030. Head wound cleansed w/wound [with wound] cleanser then mepilex foam dressing applied. Neuro's WNL at time of EMS departure. Transfer form, bed hold (received verbal request from POA) form, Right To Appeal letter obtained and completed. EMS sent with transfer form, demographics and order summary.b. Review of an incident report dated 10/18/25 and timed 9:45 AM showed the resident had an unwitnessed fall in his/her bathroom and the resident reported s/he had hit his/her head and forearm. The incident report showed the resident obtained lacerations to both areas and was transferred to the hospital for evaluation and treatment. Further review showed the resident developed a sub-[NAME] hematoma as a result of the fall and passed away on 10/22/25. c. Interview with the resident's representative on 11/18/25 at 2:58 PM revealed the resident had previously reported staff would not answer his/her call light timely, saying s/he had to wait over 20 minutes at times, and the resident would go to the bathroom without assistance, after waiting for staff. The representative confirmed on the day of the fall, the resident had taken him/herself to the bathroom, fell, and passed away as a result of a brain bleed. The representative revealed the resident could be stubborn; however, she felt the facility probably could use more staff.d. Interview with RN #1 on 11/19/25 at 9:36 AM revealed when she entered the cottage on the day of the incident, the CNA reported the resident had fallen in the bathroom. The RN revealed when she entered the resident's room, she observed the resident had obtained a hematoma to his/her head and s/he reported being on the floor for a while. She revealed her assessment of the resident, the resident requested to go to the bathroom, which she assisted him/her to do. At that time, the resident reported s/he had taken him/herself to the bathroom previously and did not use his/her walker. The RN revealed the resident was aware of what had happened, was at his/her cognitive baseline following the fall, and vital signs were normal; however, she felt the resident should go to the hospital for evaluation due to his/her use of Plavix [antiplatelet]. Further interview revealed the resident did not normally use his/her call light, she did not hear any alarms, and the CNAs had reported rounding on the resident at 9 AM. e. Interview with CNA #1 on 11/19/25 at 9:58 AM revealed she was the CNA working with resident #1 on the day of the fall. She revealed she was unfamiliar with the resident and was told s/he was fairly independent. She revealed she was the staff member who found the resident on the floor, after she observed the call light was on. The CNA revealed when she entered the room, the resident was on the floor, leaning against the recliner, and s/he was bleeding from the left side of his/her head. She revealed she notified the nurse and the other CNA, and they took over the resident's care.f. Review of the call light Call History log for resident #1 on 10/18/25 showed the emergency bathroom light was activated at 9:20 AM and cancelled at 9:57 AM, 36 minutes after activation. Further review showed the nurse call light was activated at