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	02/03/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and medical record review, the facility failed to ensure residents were free from neglect for 1 of 3 sample residents (#1) reviewed for abuse and neglect. The findings were: 1. Review of the quarterly MDS assessment dated [DATE] showed resident #1 had severely impaired cognitive skills and diagnoses which included, non-Alzheimer's dementia and depression. Further review showed the resident was incontinent, non-ambulatory, and dependent upon staff for ADL cares. The following concerns were identified:2. Interview with the CNA #1 on 2/3/26 at 4:10 PM revealed she had been a patient care tech (PCT) on 12/27/25, and was able to assist but was unable to provide direct cares to residents on her own at that time. She asked CNA #2 what time they usually got resident #1 up for the day, and was told they let him/her sleep in. CNA #2 and CNA #3 got the resident up for lunch around 11 AM. She reported the resident did not eat much, and had typically been given a shake to supplement his/her meal. She reported CNA #2 did not know how to make the shake, and asked CNA #3 to make it. She reported the resident was seated in his/her wheelchair at the end of the table after the noon meal, and she asked CNA #2 what they needed to do next for the resident and was told nothing. She reported when the evening shift arrived, she gave a report to CNA #4 and told her the resident did not eat much and had not been checked or changed all day. She assisted CNA #4 and they changed his/her wet brief, and gave him/her an ensure. She reported there had been a sore on the resident's bottom, and they were not sure if it had reopened due to sitting in the wet brief all day. She reported she alerted RN #1 to the resident's condition.3. Interview with CNA #2 on 2/3/26 at 4:26 PM revealed she got the resident up around 11 AM on 12/27/25. She stated she was the only CNA in the house, and she had called another CNA to assist her. That CNA made the resident a shake, and she gave it to resident #1 periodically throughout the day. Further interview revealed she did not move the resident out of his/her wheelchair, and the night shift put him/her to bed after dinner. She reported she had not been aware of the resident's care plan or any skin issues. 4. Interview with the SSD on 2/3/26 at 5:30 PM revealed she had discussed the incident with CNA #2, and she told her she had walked by the resident throughout the day and did not smell anything, therefore she did not check on him/her at all. The SSD reported it had been common to lay the resident down in the afternoon to protect his/her skin. Further interview revealed CNA #2 had been put on leave for the investigation and had not returned to work at the facility.5. Interview with the DON on 2/3/26 at 4:54 PM revealed the resident had a stage I pressure ulcer which periodically opened and closed. In addition, she confirmed the resident had a pressure relieving mattress.6. Interview with RN #1 on 2/3/26 at 5:19 PM revealed she was charge nurse on the night of 12/27/25. She further stated that CNA #1 reported the resident had been left in his/her wheelchair and had not been provided with a brief change, peri care, or transferred into his/her bed the prior shift. She further revealed that the CNA #1 had been told by CNA #2 that the resident did not need his/her meals and that his/her shakes (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were enough.7. Interview with the NHA on 2/3/26 at 5:32 PM confirmed CNA #2 had not done her due diligence in tending to resident #1's needs as she should have. She reported CNA #2 had gone by her sense of smell, and her expectation was that CNA #2 should have physically checked the resident's skin. She reported after the findings of the facility's investigation, she terminated CNA #2's employment. Further interview revealed there had been a discussion regarding incontinence care and checking briefs in a Tier 1 huddle, and no education had been provided to other staff. 8. Review of the facility policy titled Urinary Continence/Incontinence Assessment and Management Policy last updated 4/22/22, and provided by the DON on 2/3/26 showed .If the elder does not respond and does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a check and change strategy. C. A check and change strategy involves checking the elder's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin.9. Review of the facility policy titled Pressure Ulcer Prevention Program last updated 6/22/12, and provided by the DON on 2/3/26 showed .A. Based upon the assessment and patient's clinical condition, choices, and identified needs, the patient's plan of care will include interventions to: 1. Redistribute pressure 2. Minimize the patient's skin's exposure to moisture 3. Keep the skin clean 4. Provide appropriate pressure-redistributing support surfaces 5. Provide non-irritation surfaces 6. Maintain or improve nutrition and hydration status when feasible.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview, the facility failed to ensure MDS assessments were accurate for 3 of 4 sample residents (#2, #3, #4) reviewed for MDS discrepancies. The findings were:1. Review of the admission MDS assessment dated [DATE] for resident #2 showed the status was In Progress.2. Review of the quarterly MDS assessment dated [DATE] for resident #2 showed the status was In Progress.3. Review of the annual MDS assessment dated [DATE] for resident #3 showed the status was In Progress.4. Review of the significant change MDS assessment dated [DATE] for resident #3 showed the status was In Progress.5. Review of the admission MDS assessment dated [DATE] for resident #4 showed the status was In Progress.6. Review of the quarterly MDS assessment dated [DATE] for resident #4 showed the status was In Progress.7. Interview with the DON on 2/3/26 at 3:30 PM confirmed the MDS assessments had not been updated. She stated they had recently identified the issue and had begun a plan of correction.8. Review of the facility policy titled MDS 3.0 Completion, undated, and provided by the DON on 2/3/26 showed .1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the facility incident tracking log, and review of facility policies, the facility failed to ensure care plans were updated for 1 of 3 sample residents (#1) reviewed for care planning. The findings were:1. Review of the quarterly MDS dated [DATE] showed the resident had severely impaired cognitive skills and diagnoses which included, non-Alzheimer's dementia and depression. Further review showed the resident was incontinent, non-ambulatory, and dependent upon staff for ADL cares. Review of the facility incident tracking log showed there had been an alleged incident of neglect with the resident on 12/27/25. The following concerns were identified:2. Review of the resident's care plan initiated 12/5/23 showed the resident had mixed bladder incontinence, and goals that included I will have my dignity remain intact through the next review date and I will remain free from skin breakdown due to incontinence and brief use through the review date. The care plan had been revised on 11/19/24. 3. Review of the resident's care plan initiated 3/4/24 showed the resident was at risk for impaired skin integrity, and there were no further updates to the care plan.4. Review of a progress note dated 11/15/25 showed Coccyx area showing signs of break down, starting to open, red. Applied thin layer of barrier cream and applied silicone border Mepilex dressing for protection. Initiated skin treatment orders in TAR [Treatment Administration Record] 5. Review of a progress note dated 11/18/25 showed .Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Very moist. Activity: Chairfast. Resident is Very Limited: Makes occasional or slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Adequate. Friction and shear: Problem.BRADEN Score: 13.0.6. Review of a progress note dated 12/3/25 showed the resident had opening on his/her sacral area and a new mepilex dressing was applied.7. Interview with the DON on 2/3/25 at 3:30 PM confirmed the care plans had not been updated. She stated they had recently identified the issue and had started a plan of correction.8. Review of the facility policy titled Comprehensive Care Plans, undated, and provided by the DON on 2/3/26 showed .5. The comprehensive care plan is reviewed and revised by the interdisciplinary team at least after each comprehensive and quarterly MDS assessment.8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.