STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535054	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green House Living for Sheridan	**2311 Shirley Cove PO BOX 444, Sheridan, Wyoming, 82801**

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F0000	INITIAL COMMENTS A complaint investigation was conducted on 2/3/26. The survey was prompted by complaint 2710230. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse SSD: Social Services Director	F0000		02/27/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and medical	F0600	Deficiency Identified: The facility failed to ensure residents were free from neglect. Root Cause Analysis: 1) CNA did not deliver adequate incontinence care resulting in skin breakdown. 2) CNA lacked understanding of available resources for identification of resident specific care delivery. Residents at Risk: All residents identified as non-ambulatory, requiring staff assistance for meals, unable to independently advocate for their needs and are dependent upon staff for all ADL cares are at risk. Corrective Actions: 1) Upon learning of the abuse, CNA was removed from the schedule and terminated following the investigation. 2) Staff education on the meaning of abuse and neglect under F600. 3) All care plans and Kardexes updated to reflect appropriate intervention for any resident deemed unable to make their needs known and are dependent upon staff for ADL cares. 4) Staff education on expectations of frequent assistance to bathroom as determined by resident needs. Monitoring and Reinforcement:	03/20/2026

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

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F0600 SS = D	Continued from page 1 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 11/28/25 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	F0600	Continued from page 1 1) Record of education for all staff maintained. 2) Care plan audit per MDS schedule completed by DON or designee to ensure elder specific needs are addressed. Audit of direct assessment of incontinence care once a week times four weeks and then monthly for two months with immediate re-education for any identified variance. Audit results will be reported to QAPI monthly for three months. Compliance Date: 3/20/26 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	

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F0600 SS = D	Continued from page 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 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	F0600		

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F0600 SS = D	Continued from page 3 non-irritation surfaces 6. Maintain or improve nutrition and hydration status when feasible…"	F0600		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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 10/5/25 for resident #2 showed the status was "In Progress."	F0641	Deficiency Identified: The assessment must accurately reflect the resident's status. The facility failed to meet the requirements as evidenced by the facility's failure to ensure MDS assessments were accurate including Quarterly, Annual, Significant Change and Admission assessments and showed the status as "in progress." Root Cause Analysis: 1) Inconsistent oversight of MDS completion status 2) Failure by the MDSC to ensure assessments were completed in a timely manner. Residents at Risk: All residents are at risk. Corrective Actions: 1) All assessments cited as "in progress" immediately reviewed. 2) A 100% audit of all MDS assessments completed within the last 60 days conducted. 3) Review of all transmission validation reports within the last 60 days conducted and verified for accuracy and errors. 4) Any discrepancies identified corrected and resubmitted. Monitoring and Reinforcement: 1) The DON or designee will audit 5 MDS assessments weekly for 4 weeks, then monthly for 3 months. 2) Audits will verify timeliness, completion status and validation status. 3) Audit results will be presented to facility's QAPI meeting monthly for three months. Compliance Date: 3/20/2026 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.	03/20/2026

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F0641 SS = E	Continued from page 4 2. Review of the quarterly MDS assessment dated 1/1/26 for resident #2 showed the status was “In Progress.” 3. Review of the annual MDS assessment dated 9/7/25 for resident #3 showed the status was “In Progress.” 4. Review of the significant change MDS assessment dated 12/26/25 for resident #3 showed the status was “In Progress.” 5. Review of the admission MDS assessment dated 9/8/25 for resident #4 showed the status was “In Progress.” 6. Review of the quarterly MDS assessment dated 12/5/25 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…”	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the	F0657	Deficiency Identified: The facility failed to ensure the interdisciplinary team (IDT) reviewed and revised the care plan, with the input of the resident and/or resident representative at least quarterly, after each minimum data set assessment. Root Cause Analysis: 1) Lack of care conference processes that include standard scheduling, care plan review, roles/responsibilities. 2) Lack of updating the care plan for changes as they occur and along with the MDS schedule as required per regulations. Residents at Risk: All residents are at risk. Corrective Actions: 1) Create standard work for care conference process to include care plan review and documentation expectations; roles/responsibilities of each member of the IDT including resident, or resident representative. 2) Educate IDT to the standard work. Monitoring and Reinforcement: 1) Care plan audit completed by DON or designee weekly for four weeks, then monthly for two months, to ensure	03/20/2026

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F0657 SS = D	Continued from page 5 resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: 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 11/28/25 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	F0657	Continued from page 5 they contain evidence of the most recent review/revision and are accurate for all residents and that they are comprehensive and person-centered. 2) Record of education to IDT maintained. Care plan audit findings reported to QAPI committee monthly for 3 months until process is maintained. Compliance Date: 3/20/2026 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.	

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F0657 SS = D	Continued from page 6 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."	F0657		