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 11/19/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 11/18/25 through 11/19/25. The survey was prompted by complaint intakes #2665122, #2658707, #2658681, and #2607919. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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:	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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

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 11/19/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 1 1. Review of the admission MDS assessment dated 8/20/25 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 Watt cottage after performing med pass for Scott 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 Watt 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-dural 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	F0689		

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 11/19/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 2 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 9:39 AM, 19 minutes after the emergency bathroom light, and it was cancelled 8 minutes later at 9:47 AM. g. Interview with the facility administrator on 11/19/25 at 11:55 AM revealed the emergency bathroom light was activated by a pull cord in the resident's	F0689		

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 11/19/2025

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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 3 bathroom and the nurse call light was the regular call light activated with a push button in the resident's room. She revealed previously, the emergency call light and the nurse call light had the same tone and staff could not differentiate one from the other. Further interview confirmed she would expect resident call lights to be answered immediately and the facility developed a plan for improvement after the incident occurred. 2. The following "Root Cause Analysis and Corrective Actions" were implemented by the facility by 11/12/25 and verified during the survey: a. Resident #1 was immediately assessed on site and transferred to the hospital for evaluation and treatment on 10/18/25. b. Staff training was performed on 11/12/25. c. Tone of each call light type changed in the call light system on 11/12/25. d. Implementation of a "Handoff tool" on 11/12/25. e. Call light response time audits were implemented on 11/8/25.	F0689		