RECEIVED
WY Dept of Health
APR 30 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING ______ B. WING ______	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: DON Director of Nursing MAR Medication Administration Record MDS Minimum Date Set RD Registered Dietitian Less commonly used abbreviations will be annotated in each deficiency where used.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This plan of correction serves as the facility's allegations of compliance.	5/24/12
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure an admission MDS assessment was performed within the required fourteen days for 1 of 15 sample residents (#21). The findings were: Review of the medical record for resident #21 showed s/he was admitted on 3/23/12. Review of the initial RAI (Resident Assessment Instrument) revealed it was not completed until 4/10/12 which was five days after the fourteen day requirement. According to the Centers for Medicare & Medicaid	F 273	**483.20 Comprehensive Assessment 14 Days After Admit** The facility is committed to conducting a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition **Corrective Action:** Resident's 21's admission assessment was completed on 4/10/12 **Identification of Others:** The MDS Coordinator/Designee will conduct an audit of MDS Comprehensive Admission Assessments for residents admitted within the last 30 days to ensure completion timely completion any found to be not completed will be completed. **Systemic Changes:** The MDS/Designee will conduct a Comprehensive Assessment within 14 days of admit. A tracking tool will be used to ensure timely completion of assessments. The NHA/Designee will	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway
TITLE: administrator
(X6) DATE: 04/26/12

The POC was accepted & corrections Notified David Conaway Admin 5/8/12 via phone c [signature] State Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 273	Continued From page 1 Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, April 2012, the table entitled "RAI OBRA-required Assessment Summary" instructs: MDS completion and CAA(s) completion date is the 14th calendar day of the resident's admission (admission date +13 calendar days). Using this calculation, this resident's fourteenth day would have been 4/5/12. Interview with the MDS coordinator on 4/10/12 at 5:15 PM verified the RAI process was not completed in the required fourteen day timeframe.	F 273	review the Comprehensive Admission MDS Assessment schedule weekly during morning IDT meeting to ensure compliance. **Monitor:** The NHA/Designee to monitor for trends during review of completion timeliness & report findings during the monthly QA & A meeting which will evaluate the effectiveness of the systemic changes and implement additional interventions as needed for a period of three months or until substantial compliance is achieved.	5/24/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	**F280 RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP** The facility is committed to ensuring the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an IDT, that includes the attending physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 280	Continued From page 2 by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was updated to accurately reflect the status of 3 of 15 sample residents (#5, #73, #76). The findings were: 1. Review of the 3/28/12 admission nursing assessment and the 4/1/12 admission MDS assessment for resident #5 showed s/he was admitted to the facility with an indwelling urinary catheter. Observation on 4/9/12 at 7:30 AM confirmed the resident had an indwelling urinary catheter. Review of the 4/1/12 care plan, however, revealed it did not address the urinary catheter and, in fact, indicated the resident was on a prompted voiding program every two to four hours with check and change during rounds at night. Interview with the MDS coordinator on 4/11/12 at 5 PM verified the resident had an indwelling urinary catheter and was not on a prompted voiding schedule as indicated on the current care plan. She also said the current care plan should have been updated to reflect the indwelling urinary catheter. 2. Review of the 3/8/12 care plan for falls revealed resident #76 utilized a bed alarm and a chair alarm. However, observations of the resident on 4/10/12 and 4/11/12 revealed no bed alarm or chair alarm was in place. During an interview on 4/11/12 at 5:15 PM, the MDS coordinator stated the resident did not utilize the alarms. She stated the care plan needed to be updated to show the alarms were discontinued. 3. According to the 2/23/12 care plan, resident #73 utilized a bed alarm and a chair alarm to	F 280	**Correction Action** 1. Resident #5's care plan was updated on 4/12/12 to reflect current urinary status. 2. The falls care plan for resident # 76 was updated on 4/11/12 to reflect discontinuation of bed and chair alarm. 3. The falls care plan for resident # 73 was updated on 4/11/12 to reflect the discontinuation of bed and chair alarm. **Identification of Others:** A record review will be conducted of residents receiving the following assessments: admissions, quarterly, annual, and significant change assessments in the last 30 days by the MDS Coordinator/Designee. The IDT will review all care plans for resident's during this time period and revise care plans as needed. **Systemic Changes** The IDT will be in-serviced on or before the date of compliance by the MDS Coordinator/Designee regarding updating and revising care plans with all quarterly, annual and significant change MDS assessments. The IDT will review telephone orders, 24 Hour Report, Incident/Accidents each business day during the IDT meeting and revise care plans as needed. The MDS Coordinator/Designee will verify that care plan revisions have been completed during care conference and the Care Management Risk Review meetings → also be in-serviced to Kim	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 280	Continued From page 2 by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was updated to accurately reflect the status of 3 of 15 sample residents (#5, #73, #76). The findings were: 1. Review of the 3/28/12 admission nursing assessment and the 4/1/12 admission MDS assessment for resident #5 showed s/he was admitted to the facility with an indwelling urinary catheter. Observation on 4/9/12 at 7:30 AM confirmed the resident had an indwelling urinary catheter. Review of the 4/1/12 care plan, however, revealed it did not address the urinary catheter and, in fact, indicated the resident was on a prompted voiding program every two to four hours with check and change during rounds at night. Interview with the MDS coordinator on 4/11/12 at 5 PM verified the resident had an indwelling urinary catheter and was not on a prompted voiding schedule as indicated on the current care plan. She also said the current care plan should have been updated to reflect the indwelling urinary catheter. 2. Review of the 3/8/12 care plan for falls revealed resident #76 utilized a bed alarm and a chair alarm. However, observations of the resident on 4/10/12 and 4/11/12 revealed no bed alarm or chair alarm was in place. During an interview on 4/11/12 at 5:15 PM, the MDS coordinator stated the resident did not utilize the alarms. She stated the care plan needed to be updated to show the alarms were discontinued. 3. According to the 2/23/12 care plan, resident #73 utilized a bed alarm and a chair alarm to	F 280	quarterly, annually, and with change of condition. **Monitor** The QA & A Committee with review data obtained by the way of audits conducted by the MDS Coordinator/Designee monthly and evaluate effectiveness of the systemic changes based on trends identified & implement additional interventions as needed to ensure continued compliance for 3 months or until substantial compliance is achieved. 5 care plans will be audited each wk x4 per DON 5/9/12 1020 AM	

3A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 280	Continued From page 3 prevent falls. However, observations on 4/10/12 and 4/11/12 revealed neither alarm was in place. During an interview on 4/11/12 at 5:15 PM, the MDS coordinator stated the resident did not utilize the alarms. She stated the care plan needed to be updated to show the alarms were discontinued.	F 280	**F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** The facility is committed to providing or arranging services that must meet professional standards.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure staff followed physician's orders regarding sliding scale insulin management for 1 (#41) of 2 sample residents on sliding scale insulin for diabetes mellitus. The findings were: Review of the April 2012 physician recapitulation of orders for resident #41 showed s/he had diagnoses including insulin dependent diabetes mellitus. Review of the 3/9/12 physician order showed the resident was on a sliding scale insulin regimen four times per day in addition to the regularly scheduled doses of insulin. The following concerns were identified: a. Review of the April 2012 MAR showed the resident's blood sugar reading was 233 milligrams per deciliter (mg/dl) at 11:30 AM on 4/5/12. Review further revealed the resident was administered 5 units of Humalog insulin. According to the sliding scale orders, the resident should have been administered 10 units of	F 281	**Corrective Action:** **A.** Resident # 41 physician orders humalog sliding scale were reviewed with licensed nurses on 4/12/12. Resident number 41 MAR for 4/5/12 shows resident's blood glucose level was 112 at 430pm & required no humalog sliding scale insulin. **C/D.** Resident # 41 is receiving blood glucose monitoring and humalog insulin per sliding scale four times per day in accordance with physician's order for diagnoses diabetes mellitus. **Identification of Others** Nurse Managers and DON will observe 4 nurses administering blood glucose monitoring and sliding scale insulin in accordance of physician's orders. Any errors will be written on a Medication Variance Report and 1:1 education will be provided by the DON/Designee. **Systemic Changes** In-service education will be provided to licensed nurses by the SDC/Designee on sliding scale insulin administration using the facilities Medication Administration Policy. The DON/Designee will conduct	5/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 281	Continued From page 4 insulin. b. According to the MAR, blood sugars were scheduled daily at 6 AM, 11:30 AM, 4:30 PM, and 9 PM. Review of the April 2012 MAR showed the resident's blood sugar reading was not obtained on 4/4/12 at 4:30 PM so s/he received no sliding scale insulin. Continued review showed the blood sugar reading was 258 mg/dl at 9 PM. c. Interview with the DON on 4/17/12 at 3:30 PM verified the incorrect dose of Humalog insulin was administered at 11:30 AM on 4/5/12 and that physician orders should be followed. d. According to the Wyoming Nursing Practice Act of July 2011 and the Administrative Rules and Regulations of November 2011, pages 3-6, nursing must function under the direction of a licensed physician.	F 281	random audits for 3 months to ensure compliance. SDC will educate nurses on or before the date of compliance regarding use of the Blood Glucose Tracking/Sliding Scale Administration Record for documentation of blood sugar and administration of sliding scale insulin. **Monitor:** The QA & A Committee will review trend from audits conducted by the SDC/Designee monthly and evaluate effectiveness of the systemic changes for 3 months or until substantial compliance is achieved.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on review of diet cards, medical record review, and staff interview, the facility failed to ensure the written plan of care was followed for 1 of 15 sample residents (#76). The findings were: Review of the care plan for resident #76 revealed meal fortification was started on 3/20/12 for unplanned weight loss. However, review of the diet card and interview with the dietary manager on 4/11/12 at 12:15 PM revealed the resident's	F 282	**F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** The facility is committed to providing or arranging services by qualified persons in accordance with each resident's written plan of care. **Corrective Action:** Resident # 76 is receiving a fortified diet in accordance with physician orders and plan of care. **Identification of Others:** The RD will review all residents with significant weight loss to ensure nutritional interventions on care plan and physician orders are recorded on meal tray cards on or before the date of compliance. **Systemic Changes:** Education will be provided by the RD/Designee to licensed nurses and clerical dietary staff on using the written	5/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 282	Continued From page 5 diet card was not updated to reflect the need for meal fortification. She verified the only way dietary staff knew to provide the fortified foods was by referring to the diet card. During an interview on 4/11/12 at 2:05 PM, the RD stated that meal fortification was started on 3/20/12. However, he stated the resident went to the hospital on 3/30/12, and for some reason the meal fortification was not re-started when the resident returned to the facility.	F 282	dietary notification form to ensure dietary staff are notified when diet changes occur and so that resident meal tray cards are updated accordingly. The RD/Designee will review residents monitored for nutritional status weekly to ensure the resident's dietary tray cards are updated with new interventions. **Monitor:** The RD/Designee to monitor trends during weekly audits and report findings to the monthly QA & A Committee which will evaluate the effectiveness of systemic changes for 3 months or until substantial compliance is achieved.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 1 of 2 sample residents (#41) who were on sliding scale insulin for management of their diabetes mellitus were administered the correct doses. The findings were: Review of the April 2012 physician recapitulation of orders for resident #41 showed s/he had diagnoses including insulin dependent diabetes mellitus. Review of the 3/9/12 physician order showed the resident was on a sliding scale insulin regimen four times per day in addition to the regularly scheduled doses of insulin. The	F 309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** The facility is committed to providing the necessary care and services to each resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment. **Corrective Action:** A. Resident # 41 physician orders humalog sliding scale were reviewed with licensed nurses on 4/12/12. Resident	5/24/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 282	Continued From page 5 diet card was not updated to reflect the need for meal fortification. She verified the only way dietary staff knew to provide the fortified foods was by referring to the diet card. During an interview on 4/11/12 at 2:05 PM, the RD stated that meal fortification was started on 3/20/12. However, he stated the resident went to the hospital on 3/30/12, and for some reason the meal fortification was not re-started when the resident returned to the facility.	F 282	number 41 MAR for 4/5/12 shows resident's blood glucose level was 112 at 430pm & required no humalog sliding scale insulin. **B.** Documentation of blood glucose monitoring & insulin administration is verified by using the MAR and/or the Blood Glucose Tracking/Sliding Scale Insulin Administration Record. Resident # 41's blood sugar of 212 at 430pm on 4/4/12 with humalog insulin coverage of	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 1 of 2 sample residents (#41) who were on sliding scale insulin for management of their diabetes mellitus were administered the correct doses. The findings were: Review of the April 2012 physician recapitulation of orders for resident #41 showed s/he had diagnoses including insulin dependent diabetes mellitus. Review of the 3/9/12 physician order showed the resident was on a sliding scale insulin regimen four times per day in addition to the regularly scheduled doses of insulin. The	F 309	10 units per physician's order is documented on resident's MAR versus Blood Glucose Tracking/Sliding Scale Administration Record. **C.** Resident # 41 is receiving blood glucose monitoring and humalog insulin per sliding scale four times per day in accordance with physician's order for diagnoses diabetes mellitus. **Identification of Others** Nurse Managers and DON will observe 4 nurses administering blood glucose monitoring and sliding scale insulin in accordance of physician's orders. **Systemic Changes** In-service education will be provided to licensed nurses by the SDC/Designee on sliding scale insulin administration utilizing the facilities Medication Administration Policy. The DON/Designee will conduct weekly random audits for 3 months to ensure compliance. SDC will educate nurses on or before the date of compliance	

6A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 309	Continued From page 6 following concerns were identified: a. Review of the April 2012 MAR showed the resident's blood sugar reading was 233 milligrams per deciliter (mg/dl) at 11:30 AM on 4/5/12. Review further revealed the resident was administered 5 units of Humalog insulin. According to the sliding scale orders, the resident should have been administered 10 units of insulin. b. According to the MAR, blood sugars were scheduled daily at 6 AM, 11:30 AM, 4:30 PM, and 9 PM. Review of the April 2012 MAR showed the resident's blood sugar reading was not obtained on 4/4/12 at 4:30 PM so s/he received no sliding scale insulin. Continued review showed the blood sugar reading was 258 mg/dl at 9 PM. c. Interview with the DON on 4/17/12 at 3:30 PM verified the incorrect dose of Humalog insulin was administered at 11:30 AM on 4/5/12.	F 309	regarding use of the Blood Glucose Tracking/Sliding Scale Administration Record for documentation of blood sugar and administration of sliding scale insulin. **Monitor:** The QA & A Committee will review trend from audits conducted by the SDC/Designee monthly and evaluate effectiveness of the systemic changes for 3 months or until substantial compliance is achieved.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on review of the diet card, medical record	F 325	**F325 MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** Based on a resident's comprehensive assessment, the facility is committed to ensuring that a resident – (1)Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2)Receives a therapeutic diet when there is a nutritional problem. **Corrective Action:** Resident number 76 is receiving a fortified diet in accordance with physician orders and plan of care.	5/24/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 325	Continued From page 7 review, and staff interview, the facility failed to ensure interventions were implemented to maintain nutritional status for 1 of 3 sample residents (#76) with unplanned weight loss. The findings were: Review of the medical record showed resident #76 weighed 216.4 pounds (lbs) on 1/8/12. A 3/19/12 note by the RD documented the resident was eating less and weighed 187 lbs. On 3/20/12, there was a physician's order for meal fortification due to unplanned weight loss. On 3/20/12 the care plan was revised to include fortified foods. Interdisciplinary team (IDT) notes dated 4/3/12 and 4/10/12 revealed the resident was monitored for weight loss, and interventions included meal fortification. The following concerns were identified: a. Review of the diet card and interview with the dietary manager on 4/11/12 at 12:15 PM revealed the resident's diet card was not updated to reflect the need for meal fortification. She verified the only way dietary staff knew to provide the fortified foods was by referring to the diet card. b. During an interview on 4/11/12 at 2:05 PM, the RD stated the resident's food intakes dropped in March and s/he lost weight. The RD stated that meal fortification was started on 3/20/12. However, he stated the resident went to the hospital on 3/30/12, and for some reason the meal fortification was not re-started when the resident returned to the facility. He also stated the resident's most recent weight was 186.8 lbs on 4/9/12.	F 325	**Identification of Others:** The RD will review all residents with significant weight loss to ensure nutritional interventions on care plan and physician orders are recorded on meal tray cards on or before the date of compliance. **Systemic Changes:** Education will be provided by the RD/Designee to licensed nurses and clerical dietary staff on using the written dietary notification form to ensure dietary staff are notified when diet changes occur and so that resident meal tray cards are updated accordingly. The RD/Designee will review residents monitored for nutritional status weekly to ensure the resident's dietary tray cards are updated with new interventions. **Monitor:** The RD/Designee to monitor trends during weekly audits and report findings to the monthly QA & A Committee which will evaluate the effectiveness of systemic changes for 3 months or until substantial compliance is achieved.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	**F 465** **Corrective Action:** The identified ice on the walk-in freezer ceiling has been removed. The identified ice 3 inches in diameter on the non-skid safety floor	5/24/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 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
F 465	Continued From page 8 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the walk-in freezer was functioning as it should to prevent ice build-up on the ceiling and floor. The findings were: Observation on 4/11/12 at 10:10 AM showed the walk-in freezer had a 3 foot by 3 foot section of the ceiling near the condenser unit which was covered with ice. The floor below this area showed two spots of ice about 3 inches in diameter on the floor mat where staff would step to get items from the freezer. Interview with cook #1 on 4/11/12 at that time verified the ice had been an ongoing issue for about a year, and dietary staff dealt with the issue by chipping away the ice daily as needed.	F 465	mat has been removed. An appropriate clear plastic air curtain will be installed. **Identification of Others:** This issue has been identified and only affects the sole walk-in freezer located in facility. **System Changes:** Weekly and as needed preventative maintenance audits will be completed on walk-in freezer to ensure compliance with standard for 4 weeks then twice a month by the NHA/Designee. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3	