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 _____	C RS 07/29/2016

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 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, specialty provider interview, and review of facility policies and procedures, the facility failed to ensure residents at risk for pressure ulcers received necessary treatment and services to prevent ulcers from developing and to promote healing of existing ulcers resulting in actual harm for 1 of 5 sample residents (#108) identified as being at risk for pressure wounds. The findings were: Review of the 4/5/16 quarterly MDS assessment showed resident #108 had diagnoses that included heart failure, diabetes, hypertension, non-pressure chronic ulcer of the left foot, and a history of venous thrombosis and embolism. The resident required the extensive assistance of two people for bed mobility and transferring. Additionally, the resident was determined to be at risk for developing pressure ulcers, but did not have unhealed pressure ulcers at the time of the assessment. Review of the medical record showed the resident had a history of wounds to the feet, and review of the 4/20/16 "Head to Toe"	F 314	F314 TREATMENT AND SERVICE TO PREVENT / HEAL PRESSURE ULCERS 9/8/16 It is the practice of the facility to strive to ensure that based on comprehensive assessment of a resident, that a resident who enters the facility without a pressure sore does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing. CORRECTIVE ACTION Resident #108 was discharged from the facility on 7/19/16 to Sheridan Memorial Hospital IDENTIFICATION OF OTHERS Facility residents had head to toe skin checks completed between 7/29/16 and 7/31/16 to identify any skin concerns. Documentation was completed on any identified wounds and appropriate interventions put into place. An additional audit will be completed by date of	

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

8/22/16 Administrator

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.

8/24/16 10:55 am Spoke with Sheila Vire, DON. Plan accepted with agreed changes.

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F 314	Continued From page 1 skin check showed "Wounds are healed." Further review of the medical record showed the resident was sent to the ER on 7/19/16, and admitted to the hospital with pressure wounds to the left heel, left lateral foot, right inner ankle, and right heel. The following concerns were identified: 1. Review of the "Weekly Pressure Ulcer Record" dated 5/2/16 showed a wound had developed and was located on the left heel. The wound measured 2.0 cm (centimeters) by 2.0 cm (length by width) and the depth of the wound was unable to be determined (UTD). Further, it was described as "deep purple possible DTI [deep tissue injury] to L [left] heel. No Drainage noted, non boggy heel. There was no documented pain associated with the wound. Interventions listed as being in place at the time included LAL mattress, pillows, heel protectors, and encourage meal and protein intake. The following was noted regarding the left heel wound: a. Review of a physician order dated 5/2/16 showed "Left heal [sic] DTI Wound care every day shift cleanse with wound cleanser, skin prep to affected area and peri-wound." Review of the May 2016 TAR showed no evidence treatments were completed on 7 of 29 days. b. Review of the May 2016 TAR showed no evidence of treatments being completed on 5/21 or 5/22. Review of the "Weekly Pressure Ulcer Record" dated 5/23/16 showed the wound was larger and measured 4.2 cm by 3.6 cm, with the depth UTD. It was labeled as DTI, and "continues to present black eschar, wound edges are well attached. Noted increase size related to edema to LLE [left lower extremity]. No signs [and] symptoms of infection noted." Interventions documented as being in place include LAL mattress, pillows, heel protectors, and "cont.	F 314	compliance to verify that head to toe skin checks are completed and wound documentation and assessments are completed and treatments to wounds are documented. Follow up will be completed as needed. SYSTEMIC CHANGES will - PS 8/24/16 The nursing staff ~~was~~ be educated on skin management policies, including weekly wound evaluation and documentation on weekly pressure ulcer record and weekly non pressure ulcer record, obtaining physician orders and documentation of wound treatments by the Director of Nursing or designee. During morning clinical meeting the facility will continue to review the PCC dashboard, 24 hour report for any changes in skin condition, any new wound treatment orders, assigned head to toes skin checks for timely completion and new admissions for any skin concerns. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will continue to conduct wound rounds weekly and review / complete wound evaluation and documentation. A designated nurse will assist with wound rounds weekly for consistency and will complete rounds in	

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F 314	Continued From page 2 [continue] to encourage off loading..." The documentation also showed pain related to the wound was identified at this time. c. Review of the June 2016 TAR showed no evidence scheduled treatments were completed on 6 of 27 days. d. Review of the "Weekly Pressure Ulcer Record" dated 6/6/16 showed the wound was larger and measured 7.6 cm by 7.2 cm, with the depth UTD. It was labeled as unstageable with "full thickness dermal loss. Unable to determine depth r/t [related to] soft dark granular like tissue to wound bed. Heel boggy to tough [sic], wound edge unstable, sloughing, macerated. 40% wound edge unattached. Edema well controlled with wraps." e. Review of the "Weekly Pressure Ulcer Record" dated 6/27/16 showed the wound had not improved and continued to measure 7.6 cm by 7.2 cm, with the depth UTD. It was labeled as unstageable, with "90% firm eschar covered, 5% granular perimeter, 5% adherent slough. Punched out wound appearance, wound edges separated from eschar exposing reddened granular tissue c [with] small adherent slough. Edges non-adherent to eschar, irregular, unstable, moist. Noted odor to old dressing, no odor p [after] wound cleansing. No [change] in treatment. Education r/t [related to] laying in LAL bed vs recliner to promote healing/ alignment of legs [and] feet..." f. Review of the care plan showed the intervention "Total off load of feet, no foot pedals while in w/c [wheelchair]" was initiated on 6/30/16. g. Review of the "Weekly Pressure Ulcer Record" dated 7/14/16 showed the wound had not improved and continued to measure 7.6 cm by 7.2 cm, with the depth UTD. Further review showed "90% firm eschar, 5% granular perimeter,	F 314	absence of Director of Nursing for consistency. The Director of Nursing or designee will audit current wounds weekly for 3 months. The audit will include evaluation and staging/classification and measurement of wound and documentation, appropriate treatment orders/documentation of treatments and care plan interventions, and completion of head to toe skin checks. Corrective actions will be taken as needed. MONITORING The Director of Nursing or designee will track and trend the wound audits monthly for any trends / patterns for 3 months. The audit results will be reported to the Quality Assurance Performance Improvement Committee (QAPI). The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 314	Continued From page 3 5% soft yellow slough. No [change] noted to wound..." 2. Review of the "Weekly Pressure Ulcer Record" dated 5/2/16 showed a wound had developed on the right inner ankle. It measured 2.0 cm by 2.0 cm, with the depth UTD. It was described as a DTI and was "ruddy dark red fluid filled raised area. Intact no drainage known." Interventions documented as being in place at the time included LAL mattress, pillows, and "encourage meal [and] protein intake". The following was noted regarding the right inner ankle wound: a. Review of the physician order dated 5/2/16 showed "Right inner ankle DTI wound care as needed cleanse with wound cleanser, skin prep to peri-wound, Exuderm to cover, as needed AND every day shift every Mon, Wed, Fri cleanse with wound cleanser, skin prep to peri-wound, Exuderm to cover." Review of the May 2016 TAR showed the treatment was not documented as being completed on 2 of 12 days. b. Review of the May 2016 TAR showed no treatment was documented as being completed on Friday, 5/6/16. Review of the "Weekly Pressure Ulcer Record" dated 5/9/16 showed the wound continued to measure 2.0 cm by 2.0 cm, with the depth UTD. However, the wound had opened, and presents as "a red ruddy wound bed with uneven wound edges. Surrounding skin is pink and slightly macerated." Interventions listed included LAL mattress and pillows. c. Review of the "Weekly Pressure Ulcer Record" dated 5/30/16 showed the wound continued to measure 2.0 cm by 2.0 cm, with a depth of 0.2 cm. Further review showed "Wound bed continues to be a dark red 60% granular noted firm slough with stringy edges 35% slough. Increase eschar appearance noted wound edges	F 314		

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F 314	Continued From page 4	F 314		

remain light pink. Altered skeletal status taken into consideration. Staff educated on pillows to be used to prop feet into upright position as tolerated while maintaining off loading precautions." The documentation was unclear in describing the eschar. Interventions listed included LAL mattress and pillows.

d. Review of the "Weekly Pressure Ulcer Record" dated 6/6/16 showed the wound measured 2.0 cm by 2.0 cm by 0.4 cm, and was described as a stage 3 pressure ulcer. The wound was described as "Wound bed dark red, noted stringing adherent slough [and] necrosis to wound bed. Wound edges light pink in color, fragile, attached. Outer area intact. No neg [negative] [changes]..." Additionally, it described "60 gran [granular tissue], 20% necrotic, 20% adherent slough." Interventions listed included LAL mattress and pillows.

e. Review of the "Weekly Pressure Ulcer Record" dated 6/13/16 showed the wound measured 2.1 cm by 1.8 cm, with the depth UTD. Further review showed the wound was described as "80% eschar, 20% dark gran [granular] tissue" and "Crater wound bed, dark purple to black in color, moist, firm. Wound edges uneven, attached, dark pink. Outer tissue intact. No neg [negative] [changes]. Education provided, resident resistant to lay down." Interventions listed included LAL mattress, pillows, and heel protectors.

f. Review of the June 2016 TAR showed no evidence 4 of 13 scheduled treatments were completed.

g. Review of the "Weekly Pressure Ulcer Record" dated 7/14/16 showed the wound continued to measure 2.1 cm by 1.8 cm, with the depth UTD. Further review showed "Area remains unstageable, no [change] in wound size.

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F 314	Continued From page 5 20% adherent slough, 5% necrotic tissue, 75% smooth unstable granular tissue. Noted improved wound edge attachment continues..." 3. Review of the "Weekly Pressure Ulcer Record" dated 6/6/16 showed a new wound had developed, located on the resident's left lateral foot. The date of onset for the wound was recorded as 6/2/16; however, there was no evidence of a description of the wound prior to 6/6/16. On 6/6/16, the wound was described as a DTI, measured 14.4 cm by 4.3 cm, with the depth UTD. Further review showed "area presents with fluid filled discolored area. Area non-boggy. Wound edge soft, stable. Surrounding skin pink, soft [and] adherent. MD [physician] notified 6/2/16, aware of Charco [sic] foot, altered skeletal status. No s/s [signs/ symptoms] infection." The following was noted with regard to the left lateral foot wound: a. Review of the "Weekly Pressure Ulcer Record" dated 6/20/16 showed the wound had opened and measured 18.0 cm by 8.0 cm, with the depth UTD. It was described as "Increased discoloration to wound edge noted/ note increased size. No redness or irritation to surrounding area. Wound covering/ skin flap remains firm. Small amount serosang [serosanguineous] drainage noted to old dressing. Visible area under skin flap noted as pink granular, moist [and] fragile. Plan to leave flap in place, stabilize [sic]..." b. Review of the "Weekly Pressure Ulcer Record" dated 7/14/16 showed the wound continued to measure 18.0 cm by 8.0 cm, with the depth UTD. Further, it was described as "65% slough/thin [and] adherent, 35% pink granular. Edges pink, soft, smooth, adherent. No [change] in size. Edema cont [continues] well controlled.	F 314		

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SHERIDAN MANOR	1881 BIG HORN AVE SHERIDAN, WY 82801

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F 314	Continued From page 6 New tx [treatment] as plan to keep wounds stable awaiting surgical intervention/amputation." 4. Review of a skin/wound note dated 6/2/16 showed "...MD [physician] aware of complexities of wounds, discussed at rounds this AM. Agreeable with referring to Wound Care at this time..." 5. Review of the "Weekly Pressure Ulcer Record" dated 6/6/16 showed a new wound had developed, located on the resident's right heel. The date of onset was recorded as 6/2/16; however, there was no evidence of a description of the wound prior to 6/6/16. At that time, the wound was described as a DTI, measured 7.2 cm by 6.2 cm, with the depth UTD. Additionally, it "presents with fluid filled discolored area, boggy. Wound edge soft, unstable. Surrounding area pink, soft, unstable, sloughing. No redness or inflammation noted to surrounding area. Neuropathic in nature." The following was noted with regard to the right heel wound: a. Review of the "Weekly Pressure Ulcer Record" dated 6/13/16 showed the wound had opened, measured 7.5 cm by 8.5 cm, with the depth UTD. Further, it was described as "40% exposed, 60% nonviable skin flap remaining. Dark granular tissue noted to exposed wound bed..." b. Review of the "Weekly Pressure Ulcer Record" dated 7/14/16 showed the wound continued to measure 7.5 cm by 8.5 cm, with the depth UTD. At that time it was described as "90% firm eschar, 5% granular perimeter, 5% soft yellow slough to perimeter. Wound edges noted to have increased stability/ firmness, increased adhesion. Foot remains warm to touch, no redness, no streaking, no neg [negative]	F 314		

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SHERIDAN MANOR	1951 BIG HORN AVE SHERIDAN, WY 82801

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F 314	Continued From page 7 [changes]..." 6. Review of a purchase order showed a low air loss (LAL) mattress was ordered on 3/15/16. Review of a nurse's note dated 3/31/16, described as a late entry for 3/30/16, showed "wound nurse put an airbed in room for resident comfort. Today was reported that resident slept all night in bed with feet up. resident looks and feels much better today." The following concerns with the LAL were identfied: a. Although the LAL was listed as an intervention for the resident's wounds, review of a nurse progress note dated 4/9/16, timed 2:15 AM, showed the resident "states [s/he] sleeps pretty well in [his/her] recliner and does not like the bed because [s/he's] always "sliding out." b. Review of a nurse progress note dated 6/19/16 showed the resident wanted "to sit in [his/her] recliner in a reclining position. Says [s/he] is very uncomfortable lying in [his/her] bed, the bed is too small for [him/her]. Lying in bed causes increased pain." c. Between 4/9/16 and 6/8/16 the resident developed significant wounds on both feet. d. Telephone interview with the wound care nurse on 7/29/16 at 10:04 AM confirmed the resident did not like the air mattress. She revealed the resident reported lying flat in the mattress made it feel like a weight was pressing against his/her chest. She revealed the staff were not knowledgeable about the settings that could elevate the head of the mattress. She stated she educated the staff in mid-June regarding settings for the air mattress so they could adjust the air flow to make it more comfortable for the resident. The nurse further revealed adjusting the settings "made a huge difference," and the resident was more compliant with using the bed after that	F 314		

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F 314	Continued From page 8 point. 7. Interview with the wound clinic practitioner on 7/29/16 at 1 PM revealed the resident had been in the clinic on 6/16/16, where the wounds presented as pressure-related wounds. He stated the resident was at an extremely high risk for pressure wounds due to diagnoses and feet deformities. He further stated it was "the impression of the wound care group in general" that the resident "had extensive wounds that had not been managed well." He added "based on the way [the resident] looked in June, he was surprised they [the facility] waited that long" to contact the wound clinic. He stated the clinic had previously seen the resident, in February of 2016, and the "feet looked fine" and were healing properly. He added after the June 2016 visit he referred the resident to a podiatrist for further evaluation. 8. Interview with the resident's podiatrist on 8/2/16 at 10:10 AM revealed he saw the resident in his practice in June and recommended a vascular consult for possible amputation of both feet. He stated at the time of the resident's appointment, the wounds were necrotic and decubitus in nature. He further stated, based on the resident's comorbidities, "if [the resident] just sits there all day or lays in bed all day, it's bound to happen [development of wounds]." 9. Interview with corporate RN #1 on 7/29/16 at 9:05 AM confirmed the resident's medical record did not show evidence of ordered treatments always being completed. 10. Review of the facility policy and procedure, titled "Skin Management," revised 8/12, showed	F 314		

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F 314	Continued From page 9 "Unavoidable Pressure Ulcers: Per CMS guidelines, "unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. All of this must be clearly documented in the resident's clinical record."	F 314		