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

PRINTED: 10/06/2016
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 _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1881 BIG HORN AVE SHERIDAN, WY 82801

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F 000	INITIAL COMMENTS A complaint survey was conducted in conjuction with the recertification survey by Healthcare Licensing and Surveys on 9/19/16 through 9/22/16. The survey was prompted by complaint intakes WY00002259 and WY00002284. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. The following common abbreviations are used throughout this document: DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F253 House Keeping & Maintenance Services The facility is committed to providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Corrective Action: 1. a. The door frame to room 111 was repainted. b. The kick plate on the exit door in "game room" area was cleaned and repainted. c. The chip in the bottom corner of room 135 entrance door was fixed. d. The chip by the lower hinge to the entrance door to room 142 was fixed. 2.	11.2.16
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 8 of 8 resident areas (100 hall, 200 hall, 300 hall, 400 hall, 500 hall, dining room, game room, lobby) were clean and in good repair. The findings were: Observation on 9/21/16 from 2:41 PM to 4:41 PM revealed the following environmental issues:	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/6/16

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.

WY Dept of Health

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WBZZ11 Facility ID: WY00028 If continuation sheet Page 1 of 18

OCT 21 2016

Healthcare Licensing and Surveys

POC accepted with the agreed upon changes. DOC is 11/2/16
Spoke with Sheila Vine 10/21/16 1:49PM
Jean Hanni MS (ASCP)

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F 253	Continued From page 1 1. The following issues concerning doors and door frames were identified: a. The door frame to room 111 was scraped and exposed the underlying metal. b. The kick plate on the bottom of the exterior exit door in the "game room" area was dirty, with paint scraped off. c. In room 135, the room entrance door had a chip in the bottom corner. d. In room 142 the entrance door was chipped by the lower hinge. 2. The following issues concerning floors were identified: a. The bathroom floor in room 116 had chips that measured 2.5 by 1.5 inches and 1 inch by 0.5 inch, which created an uncleanable surface. Additionally, there was a dark substance in the gap between the bedroom and bathroom flooring. b. The bathroom floor in room 120 had a 12 inch by 12 inch tile with a break that measured 1.5 inches by 1 inch, which created a surface that could not be effectively cleaned. c. The floor in the "game room" area had a build-up of a dark substance in the door threshold. d. The floor in the bathroom in room 138 had a break that measured 3 inches by 1 inch, which created a surface that could not be effectively cleaned. e. The carpet at the threshold of room 142 was worn and discolored. f. The bathroom floor in room 142 had breaks in the 12 by 12 inch tiles near the sink that measured 3 inches by 2.5 inches and 1 inch by 1 inch. g. There was a gap in the seam of the hall carpet near the therapy department that	F 253	a. The chipped tiles in room 116 were replaced and the dark substance in the gap between the bedroom and bathroom flooring was removed. b. The chipped tile in room 120 was replaced. c. The dark substance on the floor in the door threshold in the "game room" area was removed. d. The broken tile in room 138 was replaced. e. The carpet at the threshold of room 142 was repaired f. The broken tiles on the bathroom floor near the sink in room 142 were replaced. g. The gap in the seam of the hall carpet near the therapy department was repaired. h. The cracked tiles in front of the maintenance department were replaced	11-2-16

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F 253	Continued From page 2 measured 84 inches by 0.25 inch. h. There were four 12 by 12 inch tiles in front of the maintenance department that were cracked and a tile with a break that measured 1 inch by 0.5 inch, which created a surface that could not be effectively cleaned. i. The 9 by 9 inch tiles by the dining services manager's office had a seam that measured 92 inches with a build-up of a black substance in the crack. j. The floor by the door to the outer patio had six 12 inch by 7 inch tiles that were cracked and chipped. There were five 9 by 9 inch tiles by the storage door that were cracked and broken. The threshold to the dining room entrance by the ice maker had a black substance in the length of the 71 inch seam and the 12 inch by 12 inch tiles were discolored. k. The threshold of the entrance door in room 501 had a carpet seam with a gap that measured 10 inch by 0.5 inch. The floor had a 12 by 12 inch tile that was cracked. l. The floor under the bed in room 504 had three 12 by 12 inch tiles that were chipped and had a dark substance which created a surface that could not be effectively cleaned. m. The tile in room 507 had a 12 by 12 inch tile with a broken place that measured 8 inches by 4 inches. n. The floor in room 509 had 9 by 9 inch tiles that were soiled with a black substance. The bathroom floor threshold had a chipped tile, and a build-up of a dark substance the length of the threshold seam. o. The threshold between the carpet and tile in the lobby had a build-up of a dark substance in the length of the 0.25 inch gap. p. The threshold at the entrance door in room 403 had a build-up of a dark substance in the	F 253	i. The tiles in by the dining service manager's office were repaired and cleaned. j. The cracked and chipped tiles by the outer patio and storage door were replaced and the tiles by the dining room ice machine were repaired and cleaned. k. The gap in the carpet at the threshold of room 501 was repaired. l. The chipped tiles under the bed in room 504 were repaired and black substance removed. m. The broken tile in room 507 was repaired. n. The black substance on the floor in room 509 was removed and the chipped tile in the bathroom was repaired. o. The gap in the threshold between the carpet and tile in the lobby was repaired and the dark substance was removed.	11.2.16

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F 253	Continued From page 3 seam. q. The entrance door threshold in room 402 had a build-up of a dark substance. r. The threshold at the entrance door in room 407 had a build-up of a dark substance in the seam. s. The bathroom in room 412 had three 12 by 12 inch tiles that were chipped and had a build-up of a dark substance, which created a surface that could not be effectively cleaned. t. There were five 12 by 12 inch floor tiles in room 415 by the entrance that were stained. u. Outside of room 415 were two 12 by 6 inch ceiling tiles which were chipped. v. The bathroom floor of room 311 was stained. The threshold at the bathroom door had a build-up of a dark substance and was peeling, which created a surface that could not be effectively cleaned. w. The bathroom floor in room 314 was stained with a dark substance. 3. The following miscellaneous issues concerning facility cleanliness and maintenance were identified: a. The splash guard by the sink in room 111 was damaged and scraped and exposed the underlying metal. b. The corner of the wall in room 113 by the sink was scraped and exposed the underlying metal. c. The splash guard on the bathroom wall of room 135 around and behind the toilet was coming off the wall. d. The green wall covering on the lower section of the walls in room 141 had numerous areas of bubbled surfaces, with the largest area measured at 18 inches by 3 inches. e. The green lower wall in the dining room	F 253	p. The dark substance in threshold at the entrance door of room 403 was removed. 11/2016 Q. The dark substance at the entrance door threshold of room 402 was removed. R. The dark substance at the threshold at the entrance door in room 407 was removed. S. The chipped tile in room 412 was repaired and dark substance removed. T. The 5 stained tiles in room 415 were cleaned U. The 2 chipped tiles outside of room 415 were replaced v. The stain on the bathroom floor of room 311 was removed and the dark substance at the bathroom door was removed. w. The stains to the floor of room 314 were removed as well as the dark substance.	

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F 253	Continued From page 4 had scraped-off paint with dark stains the length of the wall at chair height. f. There were ceiling tiles in room 507 above the bed by the window and above the dresser that were hanging loose. There were brown-stained ceiling tiles above the bed. g. The wall in room 513 near the closet was scraped and exposed the underlying metal. There were 12 by 12 inch tiles above the bed by the window that sagged and were loose. There were several areas of peeled paint. The wall by the bed had 5 inches by 2 inches of exposed metal. h. The ceiling in room 403 had 3 loosened tiles. The wallpaper had 2 seams that were peeled the vertical length of the wall. i. The ceiling in room 402 had stained tiles and 6 loosened tiles. The register by the window had scraped paint and rust. j. The register in the bathroom of room 407 had rust. The wallpaper had 2 seams that were peeled the vertical length of the wall. The ceiling had 8 loosened tiles. k. The silicone around the bottom of the toilet in room 412 was cracked, and peeled away which created a broken seal, with a dark substance encircling the base of the toilet. l. The ceiling in room 307 had two 12 by 12 inch ceiling tiles that were loose. There were four 12 by 12 inch ceiling tiles by the window that were stained. m. The ceiling in room 311 had four 12 by 12 inch tiles that were loose. n. The wallpaper in room 304 had 1 seam that was peeled the vertical length of the wall. 4. Tour with the maintenance director on 9/22/16 at 9:18 AM confirmed the issues with building damage and cleanliness. The maintenance manager further confirmed the facility did not	F 253	a. The splash guard by the sink in room 111 was repaired b. The corner of the wall in room 113 was repaired c. The splash guard on the bathroom floor wall of room 135 around and behind the toilet was repaired d. The bubbled areas of the green wall covering on the lower section of the walls in room 141 were repaired. e. The scrapes and stains at chair height on the green lower wall in the dining room were cleaned and repaired. f. The ceiling tiles in room 507 above the bed by the window and above the dresser were repaired and the ceiling tiles above the bed were replaced. g. The scraped wall in room 513 was repaired and the loose tiles above the bed by the window were repaired. The peeling paint and the wall by the bed was repaired.	11.21.16

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F 253	Continued From page 4 had scraped-off paint with dark stains the length of the wall at chair height. f. There were ceiling tiles in room 507 above the bed by the window and above the dresser that were hanging loose. There were brown-stained ceiling tiles above the bed. g. The wall in room 513 near the closet was scraped and exposed the underlying metal. There were 12 by 12 inch tiles above the bed by the window that sagged and were loose. There were several areas of peeled paint. The wall by the bed had 5 inches by 2 inches of exposed metal. h. The ceiling in room 403 had 3 loosened tiles. The wallpaper had 2 seams that were peeled the vertical length of the wall. i. The ceiling in room 402 had stained tiles and 5 loosened tiles. The register by the window had scraped paint and rust. j. The register in the bathroom of room 407 had rust. The wallpaper had 2 seams that were peeled the vertical length of the wall. The ceiling had 8 loosened tiles. k. The silicone around the bottom of the toilet in room 412 was cracked, and peeled away which created a broken seal, with a dark substance encircling the base of the toilet. l. The ceiling in room 307 had two 12 by 12 inch ceiling tiles that were loose. There were four 12 by 12 inch ceiling tiles by the window that were stained. m. The ceiling in room 311 had four 12 by 12 inch tiles that were loose. n. The wallpaper in room 304 had 1 seam that was peeled the vertical length of the wall. 4. Tour with the maintenance director on 9/22/16 at 9:18 AM confirmed the issues with building damage and cleanliness. The maintenance manager further confirmed the facility did not	F 253	h. The 3 loosened tiles in room 403 were repaired and peeling seams in the wallpaper were repaired. 11.2.16 i. The stained and loosened tiles in room 402 were replaced and the register by the window was repaired and painted. j. The register in the bathroom of 407 was cleaned and repainted. The 2 seams in the wall were repaired and the 8 loosened tiles were repaired. k. Silicone around the toilet in room 412 was removed and new silicone applied. The dark substance around the toilet was removed. l. The 2 loosened tiles in room 307 were repaired and the 4 stained tiles were replaced. m. The 4 loosened tiles in room 311 were repaired. n. The seam in the wall paper in room 304 was repaired.	

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F 253	Continued From page 5 have a plan with a timeframe for making the repairs.	F 253	ID of Others: An audit will be conducted by the NHA and Maintenance Director on or before the date of compliance to identify loosened and stained ceiling tiles, cracked silicone, seams in wall paper, gaps in carpet/tile thresholds, chipped, broken or stained floor tiles, areas of paint peeling, metal exposer and chips to doors. A work order will be completed for the repairs. Systemic Changes: The NHA or designee will complete weekly environmental rounds to identify areas in need of repair and ensure a work order is completed and repairs are completed on the work order. Monitoring: The QAPI Committee will review any trends identified monthly until substantial compliance is achieved and then bi-monthly thereafter.	11.2.16
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the Resident Assessment Instrument User's Manual,	F 278		

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F 278	Continued From page 6 and staff interview, the facility failed to ensure the MDS assessment was accurate and/or was certified as being complete in a timely manner for 10 of 18 sample residents (#3, #18, #20, #22, #30, #46, #60, #89, #92, #98). The findings were: Regarding accuracy of assessments: 1. Review of the quarterly MDS assessments with assessment reference dates (ARDs) of 8/25/16 and 5/25/16, and the annual MDS assessment dated 2/16/16 revealed resident #46 was marked as having received the influenza vaccine in the facility during the most recent influenza vaccination season. However, review of the influenza vaccination documentation showed the resident refused the vaccination on 10/8/15. The MDS coordinator on 9/22/16 at 8:17 AM confirmed the discrepancy and explained the information had not been retrieved from medical records storage. 2. Review of the quarterly MDS assessment with an ARD of 8/2/16 showed resident #30 had received the pneumococcal vaccination. Review of the vaccination record showed the resident received the pneumococcal vaccination or "Pneumovac" in the left deltoid on 3/10/15. However, the significant change MDS assessment, with an ARD of 8/12/16, did not indicate the resident had received the vaccination. The MDS coordinator on 9/22/16 at 8:17 AM confirmed the discrepancy and explained the information had not been retrieved from medical records storage. Regarding timeliness of MDS assessment completion:	F 278	Sheridan Manor F278 Corrective Action: Resident #3, #18, #20, #22, #30, #46, #60, #89, #92 and #98 had assessments completed untimely as noted in the 2567. As of 11.2.16 (Date of compliance) the next assessment for #3, #20, #22, #30, #46, #60, #89, #92 and #98 will have assessments completed timely per the RAI guidelines. Resident #46's assessments with ARD's of 2/16/16, 5/25/16 and 8/25/16 have been modified to reflect refusal of the Flu Vaccine.	

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F 278	Continued From page 7 According to page 2-15 of "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.13" by the Centers of Medicare and Medicaid Services, the MDS completion date (item Z0500B) can be no later than the 14th calendar day of the resident's admission for an admission assessment and no later than the ARD plus 14 days for an annual assessment. For a significant change assessment, the completion date can be no later than 14 days after the determination that a significant change occurred. The following concerns were identified: 1. Review of the admission MDS assessment, with an assessment reference date (ARD) of 2/5/16, revealed resident #92 was admitted on 1/28/16. Further review of section V showed the RN certified the assessment as being complete on 2/22/16 (the 26th day after admission). 2. Review of the significant change MDS assessment for resident #98 revealed an ARD of 8/5/16. Review of section V showed the RN didn't certify the assessment as being complete until 8/29/16 (24 days after the ARD). 3. Review of the significant change MDS assessment for resident #89 revealed an ARD of 4/15/16. However, the RN did not certify the assessment as being complete at section V until 5/23/16 (38 days after the ARD). 4. Review of the admission MDS assessment, with an ARD of 3/14/16, revealed resident #18 was admitted on 3/7/16. Further review of section V showed the RN certified the assessment as being complete on 4/1/16 (the 25th day after admission).	F 278	Resident #30's assessment with ARD of 8/12/16 has been modified to reflect receipt of the Pneumonia vaccine. Identification of Others: Assessments will be completed within the RAI guidelines as of 11.2.16 and going forward. A review of assessments completed within the last 30 days will be conducted to determine if section O0250 (O2050A, O0250B and O0250C) and section O0300 (O0300A and O0300B) have been coded accurately to reflect resident Flu and Pneumococcal Vaccinations. Any assessments found to be inaccurate will be modified.	

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F 278	Continued From page 8 5. Review of the significant change MDS assessment for resident #3 revealed an ARD of 7/22/16. Review of section V showed the RN didn't certify the assessment as being complete until 8/8/16 (17 days after the ARD). 6. Review of the significant change MDS assessment for resident #20 revealed an ARD of 7/16/16. However, the RN didn't certify the assessment as being complete at section V until 8/8/16 (24 days after the ARD). 7. Review of the annual MDS assessment revealed an ARD of 3/4/16 for resident #60. Review of section V showed the MDS coordinator certified the assessment as being complete on 3/28/16 (24 days from the ARD). 8. Review of the significant change MDS assessment revealed an ARD of 11/17/15 for resident #22. Review of section V showed the MDS coordinator certified the assessment as being complete on 12/7/15 (20 days from the ARD). 9. During an interview on 9/21/16 at 2:50 PM the MDS coordinator stated that after she certified an assessment as being complete, if it had not been transmitted yet, sometimes she went back into the assessment to make changes. She stated that when she goes back into the assessment, the computer re-signs the assessment and uses that date. She acknowledged that the assessments were not completed timely based on the dates at section V of the assessments.	F 278	System Measures: DDCM (District Director of Care Management)/Designee will educate the RCMD (Resident Care Management Director) on assessment timeliness utilizing the RAI manual chapter 2 references specifically on or before 11.2.16. DDCM/Designee will educate the RCMD on assessment accuracy specifically section O with review of the RAI manual chapter 3 references on or before 11.2.16. DON/Designee will review 3-4 MDS assessments per week to validate timely completion as well as accuracy of sections O0250 and O0300 for four	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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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 09/22/2016

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 278	Continued From page 8 5. Review of the significant change MDS assessment for resident #3 revealed an ARD of 7/22/16. Review of section V showed the RN didn't certify the assessment as being complete until 8/8/16 (17 days after the ARD). 6. Review of the significant change MDS assessment for resident #20 revealed an ARD of 7/15/16. However, the RN didn't certify the assessment as being complete at section V until 8/8/16 (24 days after the ARD). 7. Review of the annual MDS assessment revealed an ARD of 3/4/16 for resident #60. Review of section V showed the MDS coordinator certified the assessment as being complete on 3/28/16 (24 days from the ARD). 8. Review of the significant change MDS assessment revealed an ARD of 11/17/16 for resident #22. Review of section V showed the MDS coordinator certified the assessment as being complete on 12/7/16 (20 days from the ARD). 9. During an interview on 9/21/16 at 2:50 PM the MDS coordinator stated that after she certified an assessment as being complete, if it had not been transmitted yet, sometimes she went back into the assessment to make changes. She stated that when she goes back into the assessment, the computer re-signs the assessment and uses that date. She acknowledged that the assessments were not completed timely based on the dates at section V of the assessments.	F 278	weeks then monthly for three months. Monitor: The facility will audit compliance through weekly reviews of conducted assessments. RCMD will report results to the QAPI committee for tracking and trending.	11-2-16
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	**F323** The facility is committed to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** Resident #42 was discharged on 9/27/16	11-2-16

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SHERIDAN MANOR	1861 BIG HORN AVE SHERIDAN, WY 82801

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F 323	Continued From page 9 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and medical record review, the facility failed to ensure residents were protected from aggressive behaviors exhibited by 1 of 6 sample residents (#42) who required behavior monitoring. The findings were: 1. During a confidential group interview on 9/20/16 at 1 PM, five of the ten residents stated they were concerned about the wandering behavior of resident #42. 2. Review of the 8/10/16 admission MDS assessment for resident #42 showed diagnoses that included intellectual disabilities, depression, asthma, and weakness. Further review of the assessment showed the resident self-propelled his/her wheelchair independently, had moderate cognitive impairment, and exhibited physical and verbal behaviors directed toward others. Additionally, the review revealed the resident's behavior put others at significant risk for physical injury, significantly intruded on the privacy or activities of others, and significantly disrupted care or the living environment. Review of the resident's care plan, revised 9/20/16, showed the resident had the potential to be physically	F 323	ID of Others: 11.2.16 Nursing progress notes and behavior monitoring sheets for the past 30 days will be reviewed by the DON or designee to identify any residents with aggressive behaviors. Any residents found to have aggressive behaviors will be reviewed by the IDT for individualized care plan interventions. Effectiveness of interventions will be monitored weekly during the Care Management Risk Review meetings by the IDT. Systemic Changes: Nurses and IDT will receive education the DON/designee regarding behavior monitoring documentation including listing medications on the Behavior Monitoring sheet, documentating behaviors on the Behavior Monitoring sheets, and using specific target behaviors and individualized interventions. The IDT will review behavior progress notes during the am IDT meeting daily. The DON/Designee will conduct weekly audits of Behavior Monitoring sheets weekly x 1 month then monthly until substantial compliance is achieved.	SV 10-20-16

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F 323	Continued From page 10 aggressive. Further review revealed the following approaches for this problem: "The triggers for physical aggression was being misunderstood; analyze and document times of day, places, circumstances, triggers, and what de-escalates behavior; administer medications as ordered; and intervene before agitation escalates." The following concerns were identified: a. Review of August and September 2016 incidents and nurse progress notes revealed the resident hit and/or kicked and bruised other residents on 8/7/16, 8/10/16, and 8/11/16, and 2 times on 8/13/16. b. Review of the nurse's progress notes, dated 8/15/16, revealed the resident continued to go into other residents' rooms, had confrontations with other residents, and "when told not to do something, has a tendency to hit or kick." c. Review of the nurse's progress note, dated 9/5/16 revealed the resident had been stealing food from other resident rooms. The resident became agitated when asked to leave, yelled and attempted to hit staff members. d. Interview with RN #1 on 9/21/16 at 3 PM revealed the resident wandered in and out of other resident rooms. She stated the resident usually hit and kicked other residents when the other residents told him/her to leave or stop taking their possessions. The RN stated staff had successfully decreased the incidents by providing diversional activities for the resident but physical aggression towards other residents continued to be a problem. The RN further stated when staff saw the resident entering other resident rooms they intervened, but staff were not always present when the resident exhibited this behavior. e. Interview with resident #41 on 9/21/16 at 4:20 PM revealed resident #42 hit resident #41 on 9/20/16 during the night. Observation at that time	F 323	Monitoring: The QAPI will evaluate the effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	11.2.16

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F 323	Continued From page 11 revealed a nickel sized bruise on his/her arm that the resident stated occurred when resident #42 hit him/her. f. Periodic observations of the resident on 9/20/16 and 9/21/16 revealed the resident wandered throughout the facility independently without staff supervision or monitoring. g. Interview with the DON on 9/21/16 at 4:30 PM revealed staff had tried various diversional activities and redirected the resident when necessary. She further stated the resident had improved. However, the DON did not provide evidence of interventions for ensuring other residents would not continue to be injured by resident #42's behavior.	F 323	F329 11.2.16 The facility is committed to ensure each resident's drug regiment must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	**Corrective Action:** Resident #42 was discharged on 9/27/16. **ID of Others:** An audit of Behavior Monitoring Sheets for the past 30 days will be conducted by the DON or designee behavior sheets will be updated to include medications and specific target behaviors and individualized interventions. 11.2.16	

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F 329	Continued From page 12 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide the medication and behavior monitoring needed to ensure medication regimens were free of unnecessary drugs for 1 of 18 sample residents (#42). The findings were: Review of the 8/10/16 admission MDS assessment for resident #42 showed diagnoses that included intellectual disabilities, depression, asthma, and weakness. Review of the assessment showed the resident self-propelled his/her wheelchair independently, had moderate cognitive impairment, and exhibited physical and verbal behaviors directed toward others. Further review revealed the resident's behavior put others at significant risk for physical injury, significantly intruded on the privacy or activities of others, and significantly disrupted care or the living environment. This review also showed the resident received daily doses of an antipsychotic medication. Review of the care plan, revised 9/20/16, showed the resident had the potential to be physically aggressive. Further review revealed approaches for this problem included the following: "The triggers for physical aggression was being misunderstood; analyze and document times of day, places, circumstances, triggers, and what de-escalates behavior; administer medication as ordered, and intervene before agitation escalates." Review of the August and	F 329		

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F 329	Continued From page 13 September 2016 medication administration records showed Latuda 20 milligrams (mg) (an antipsychotic medication) was ordered on 8/4/16, Olanzapine 5 mg, (an antipsychotic medication) two times a day as needed was ordered on 8/3/16 for psychosis, and Sertraline 50 mg, (an antidepressant medication) daily was ordered on 8/3/16 for depression. The following concerns were identified during review of the facility's system for monitoring and identifying unnecessary medications for resident #42: a. The section for medications was blank on the August 2016 behavior monthly flow sheet. Further review of the documentation showed the targeted behaviors were kicking and striking out/hitting. According to this behavior monthly flow sheet the identified behaviors occurred on 8/7/16 and 8/12/16. However, review of the August and September 2016 incident log and nurses' progress notes, showed the resident kicked and hit other residents on 8/7/16, 8/10/16, 8/11/16, and 8/13/16. b. Review of the September 2016 behavior monthly flow sheet showed the medications affecting behavior were Latuda, Olanzapine, and Sertraline and the targeted behaviors were mood changes, hallucinations and anxiety. Review of the September 2016 nurse's notes showed the resident did not have episodes of hallucinations or anxiety, but exhibited wandering, hitting and kicking behaviors that had not been included on the behavior monthly flow sheet. c. Interview on 9/21/16 at 5:30 PM DON verified the September 2016 behavior monthly flow sheet did not include monitoring for kicking and hitting behaviors that had been observed by staff.	F 329	**Systemic Changes:** 10.2.16 Nurses and IDT will receive education the DON/designee regarding behavior monitoring documentation including listing medications on the Behavior Monitoring sheet, documentating behaviors on the Behavior Monitoring sheets, and using specific target behaviors and individualized interventions. The IDT will review behavior progress notes during the am IDT meeting daily. The DON/Designee will conduct weekly audits of Behavior Monitoring sheets weekly x 1 month then monthly until substantial compliance is achieved. **Monitoring:** 10.2.16 The QAPI will evaluate the effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	

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SHERIDAN MANOR	1551 BIG HORN AVE SHERIDAN, WY 82801

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F 371 F 371 SS=E	Continued From page 14 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by; Based on observation and staff interview, the facility failed to ensure nutritional supplements were labeled with the thaw date in 3 of 4 refrigerators in which the supplements were stored. In addition, the facility failed to ensure equipment was maintained in a sanitary environment in 1 of 1 kitchens and failed to ensure 1 of 6 refrigerators were maintained in a sanitary manner. The findings were: 1. Observation on 9/21/16 from 3 PM until 3:15 PM revealed thawed nutritional supplements were stored in the refrigerators on the Chapel, Deer Lane, and Courtyard units. The supplements were not labeled with the thaw date. Review of the instructions on the supplement revealed the product was good for 14 days after thawing. During an interview on 9/22/16 at 8:50 AM the dietary manager confirmed the supplements should have been labeled with the thaw date and stated he had new staff working in the department.	F 371 F 371	**F371 Food Procure, Store/Prepare/Serve – Sanitary** 11.2.16 The facility is committed to (1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. **Corrective Action:** 11.2.16 The undated thawed nutritional supplements on Chapel, Deer Lane, and Courtyard units were disposed of immediately when identified. The wall mounted fan in each of the dish rooms and pipe for the sprinkler system were cleaned. The 2 cracked plastic pitchers were removed and replaced. The brown substance spilled in the Courtyard Unit refrigerator was cleaned. **ID of Others:** 11.2.16 An audit of resident refrigerators was completed by the dietary manager and any	

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F 371	Continued From page 14	F 37	undated food items were removed and any	11.2.16
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure nutritional supplements were labeled with the thaw date in 3 of 4 refrigerators in which the supplements were stored. In addition, the facility failed to ensure equipment was maintained in a sanitary environment in 1 of 1 kitchens and failed to ensure 1 of 6 refrigerators were maintained in a sanitary manner. The findings were: 1. Observation on 9/21/16 from 3 PM until 3:15 PM revealed thawed nutritional supplements were stored in the refrigerators on the Chapel, Deer Lane, and Courtyard units. The supplements were not labeled with the thaw date. Review of the instructions on the supplement revealed the product was good for 14 days after thawing. During an interview on 9/22/16 at 8:50 AM the dietary manager confirmed the supplements should have been labeled with the thaw date and stated he had new staff working in the department.	F 37	spills cleaned. An audit of food containers was completed by the dietary manager and any cracked containers were replaced. An audit of surfaces of vents and pipes and ledges was completed by the dietary manager to ensure surfaces were free of dust. Any areas found to have dust were cleaned. **Systemic Changes:** 11.2.16 The NHA/Designee will educate the dietary manager regarding the removal of cracked food storage containers, removal of dust from fans, pipes, vents and ledges. The RD/designee will educate the dietary manager and staff regarding dating thawed food items. The dietary manager/designee will complete audits three times weekly of refrigerators on nursing units to ensure thawed food items are dated and they are free of spills. The DM/Designee will educate the dietary staff regarding the cleaning schedule. A weekly audit tool will be completed by the NHA/designee to	

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F 371	Continued From page 15 2. Observation on 9/19/16 at 4:36 PM and again on 9/21/16 at 10:15 AM revealed the facility had a wall-mounted fan in each of the two dish machine rooms. The fans were visibly dusty and dirty and were operational during the observations. The fans were blowing air towards clean dishes. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation of the main kitchen on 9/19/16 at 4:36 PM and again on 9/22/16 at 8:45 AM revealed the overhead pipe for the fire sprinkler system had visible dust and dirt on it. The pipe was located above two meal prep tables. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Observation in the kitchen on 9/21/16 at 10:15 AM revealed two plastic beverage pitchers on a shelf which were worn with visible crackling, creating a surface that could not be effectively cleaned. During an interview on 9/22/16 at 8:50 AM the dietary manager confirmed the two pitchers should be replaced. According to Food Code 2013, U.S. Public Health Service: 4-201.11 "EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions.	F 371	ensure pipes, vents and ledges are free of dust. **Monitoring:** 11.2.16 The Dietary Manager or designee will report the results of the dietary audits to the QAPI Committee monthly for tracking and trending. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 371	Continued From page 16 5. Observation on 9/20/16 at 5 PM and again on 9/21/16 at 3 PM in the Courtyard unit revealed the inside door of the refrigerator had a spill of a brown substance that started on the 2nd shelf and dripped down to the 3rd shelf. During an interview on 9/22/16 at 8:50 AM the dietary manager stated he thought nursing was responsible for cleaning the unit refrigerators, but stated that nursing would probably say it was the responsibility of dietary staff. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	**F465** **Safe/Functional/Sanitary/Comfortable Environment** The facility is committed to providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public. **Corrective Action:** The two wall vents and the overhead pipe for the fire sprinkler system in the hallway between the main kitchen and the dish machine rooms and the horizontal surface of the Ecolab monitoring station were cleaned. The chipped and peeling area around the window in the main kitchen was repainted. The 3 cracked tiles in front of the back exit door of the dry storage room were replaced along with the area of missing tile in front of the walk in freezer. The 4 cracked tiles in front of the walk in freezer were replaced. The area around the drain in the floor in the area of the walk in freezer was cleaned and the tiles replaced. **ID of Others:**	11.2.16 11.2.16 11.2.16
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 maintain the kitchen and kitchen areas in a sanitary manner. The findings were: 1. Observations in the kitchen area on 9/19/16 at 4:36 PM and again on 9/22/16 at 8:45 AM revealed the following concerns: a. The hallway between the main kitchen and	F 465		

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F 465	Continued From page 17 the dish machine rooms had two wall vents and an overhead pipe for the fire sprinkler system which were visibly dusty. In addition, the horizontal surfaces of mounted items (Ecolab monitoring station, ledge where clipboards were hanging) in the hallway were visibly dusty. b. The paint was chipped and peeling around the window in the main kitchen, which created a surface that could not be effectively cleaned. c. The floor in the dry storage room consisted of 12 inch by 12 inch tiles. Three tiles in front of the back exit door were cracked, and there was an area of missing tile which measured 11 inches by 1 inch. In front of the walk-in freezer and refrigerator, there were 4 tiles which were cracked. In addition, there was missing tile around the drain in the floor and in an area in front of the walk-ins which measured 2 inches by 6 feet. The area of missing tile was visibly dirty. 2. During an interview on 9/22/16 at 8:50 AM the dietary manager acknowledged the findings. He stated the maintenance supervisor was aware of the paint around the window and the floor in the dry storage room. 3. On 9/22/16 at 9:30 AM the maintenance supervisor stated the paint around the windows and the floor in the dry storage room was going to be fixed, but stated she did not have a written timetable for the repairs.	F 465	The NHA and Maintenance Director will complete an audit of facility before date of compliance to identify any areas that are not safe, functional, sanitary or comfortable. Actions will be taken as needed for any identified concerns. **Systemic Changes:** 11.2.16 The Dietary Manager will be educated by NHA or designee on maintaining a safe, functional, sanitary and comfortable environment in non- food service areas of the dietary department. The Dietary Manager will educate dietary staff on maintaining a safe, functional, sanitary and comfortable environment in non-food service areas of kitchen and process for reporting concerns. 11.2.16 The Dietary Manager will complete an audit of kitchen weekly to identify concerns r/t sanitary conditions. Corrective actions will be taken as needed for identified concerns. 11.2.16	

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

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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 _____	C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

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