POC accepted 6/28/11 jc

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Wyoming Dept of Health

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

PRINTED: 06/16/2011
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 |
|---|---|---|---|
| Office of Healthcare Licensing and Surveys | 535026 | A. BUILDING _____ B. WING _____ | C 04/28/2011 |

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

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br>RN - registered nurse<br>LPN - licensed practical nurse<br>DON - director of nursing<br><br>MDS - Minimum Data Set<br>CNA - certified nursing assistant<br>CDM - certified dietary manager<br>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.<br>This plan of correction serves as the facility's allegation of compliance. | |
| F 244 SS=E | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, observation, and review of the resident council meeting minutes and grievance follow up information, the facility failed to act on 1 of 1 grievance. The findings were:<br><br>Review of the 1/27/11 resident council meeting minutes showed the residents were "Mad about TV [television] being moved from front lobby." A confidential interview with eight residents revealed this issue was not resolved, and the residents continued to be upset about the relocation of the television. Review of the 1/27/11 | F 244 | **F 244**<br>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of the residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.<br>**Corrective Action:**<br>The resident council concern regarding the location of the television was reviewed with regards to the decision and plan at the resident council meeting on 5/3/2011<br>**Identification of Others:**<br>Resident Council meeting held on 5/3/11, at which time residents were asked if there were any unresolved concerns. No unresolved concerns were identified and documented on a concern form for resolution by the IDT. | 6/6/11 |

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

David Conaway | administrator | 06/21/11

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.

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Wyoming Dept of Health
JUN 23 2011
Office of Healthcare Licensing and Surveys

POC accepted. Call to David Conaway, NHA on 6/28/11 @ 1pm - message left. Janelle Conlon 10781L

6/28/11
JC



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| F 244 | Continued From page 1<br>concern form presented to the administrator showed eleven residents complained because the area where the TV was relocated was too small and had space for no more than 2-3 residents at one time. Observation during all dates of the survey showed the television area was significantly smaller than the front lobby area and would be able to accommodate just a few residents. Review of the resident council concern follow up form dated 1/27/11 showed the decision to move the TV was a "company directive...unable to make other changes. This is to promote a more inviting lobby/entrance area w/ [with] less noise." Interview with the administrator on 4/28/11 at 11:05 AM revealed the TV was relocated due to noise issues and the residents were informed in advance of this decision. The administrator confirmed he had not addressed this issue with the residents any further. | F 244 | **System Measures:**<br>The facility reviewed its Concerns Resolution policy to assure that the policy adequately explained the steps necessary to promptly address and correct, where possible, concerns raised by residents and their families. In accordance with the Concern, Action, Response, Sustain (C.A.R.S.) process all concerns received orally or in writing shall be documented on a Concern Form. Concerns related to alleged abuse or neglect are to be reported to the Administrator or Director of Nursing immediately. All other concerns are to be reported to the Administrator within 24 hours of receipt or on the first business day following receipt. Concerns must be addressed within 72 hours. If it is not possible to address a concern within 72 staff must contact the resident within 72 hours to advise him/her on status of resolution.All concerns are discussed each morning with the Interdisciplinary Team ("IDT"). During the meeting the IDT will determine who should investigate the concern. The individual assigned will have 3 days to complete the investigation. The investigation will be forwarded to the Administrator by the 3rd day. | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns; | F 272 | | 6/6/11 |



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6/28/11
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| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns; | F 272 | **F 272**<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the state. The assessment must include at least the following:<br>Identification and demographic information; customary routine; cognitive patterns; communication; | 6/6/11 |



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| F 272 | Continued From page 2<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to provide comprehensive assessments in various areas for 2 of 16 sample residents (#3, #18). The findings were:<br><br>1. According to the 4/13/11 admission MDS assessment, resident #3 was frequently incontinent of bowel and required a comprehensive assessment to determine the causes and contributing factors. Review of the 4/11/11 assessment information showed the facility documented the resident's bowel status as "continent." However, review, with RN #6, of the | F 272 | vision; mood and behaviors; psychosocial well being; physical functioning and structural problems; continence; disease diagnosis and health conditions; dental and nutritional status; skin conditions; activity pursuits; medications; special treatments and procedures; discharge potential; documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and documentation of participation in assessment.<br>**Corrective Action:**<br>Resident #3 has discharged from the facility.<br>Resident #18 has had a significant change is status assessment completed to reflect a comprehensive assessment of care areas triggered including risk for pressure ulcers.<br>**Identification of Others:**<br>Residents newly admitted to the facility requiring a comprehensive admission assessments, residents requiring a annual assessment and resident's requiring a significant change in status assessment are at risk<br>**Systemic Changes:**<br>The MDS Coordinator/designee will complete Care Area Assessments (CAA) for all comprehensive assessments. The MDS Coordinator will include associated causes and | |



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| F 272 | Continued From page 3<br>CNAs' documentation of daily bowel function showed the resident was frequently incontinent. On 4/27/11 at 3:23 PM the RN reviewed the assessment information and confirmed it was incorrect. She verified a comprehensive bowel assessment had not been completed for this resident.<br><br>2. On 4/25/11 at 3:30 PM, RN #2 stated resident #18 was admitted with pressure ulcers, and medical record review confirmed the statement. Medical record review also showed the resident was admitted with diagnoses including anemia, peripheral vascular disease, thyroid disorder, chronic obstructive pulmonary disease, and congestive heart failure. Observation on 4/27/11 at 11:05 AM showed the resident had healing pressure ulcers on the coccyx and left heel. Review of the assessment information showed the only documented pressure ulcer risk factor for this resident was decreased mobility. On 4/28/11 at 10:30 AM, the MDS coordinator acknowledged other factors such as nutrition and decreased circulation would impact the resident's risk for developing other pressure ulcers. She confirmed the assessment lacked a comprehensive determination of factors impacting the resident's risk of developing additional pressure ulcers. | F 272 | effects. Determine whether multiple conditions are related. Suggest the need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests and consulting psychiatrist. Determine if a resident is a good candidate for rehabilitative interventions. Identify the need for referral to an expert in an area of resident concern. Begin to formulate care plan goals and approaches.<br>The MDS Coordinator/designee will complete the Care Area Assessments (CAA) for all comprehensive assessments per the RAI manual chapter 4 page 5. CAA's will include the nature of the issue or condition, causes and contributing factors, complications affecting or caused by the care area for this resident, risk factors that arise because of the presence of the condition that affect the staff's | |
| F 274 SS=E | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the | F 274 | decision to proceed to care planning, factors that must be considered in developing individualized care plan interventions, include appropriate documentation to justify decision to plan care or not to plan care for the individual resident, and the need for referrals or further evaluation by appropriate health professionals, what research, resources or | 6/6/11 |

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| F 274 SS=E | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the | F 274 | | 6/6/11 |

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| F 274 | Continued From page 4<br>resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and staff interview, the facility failed to ensure a significant change MDS assessment was completed for 2 of 3 sample residents (#17, #52) who required this type of assessment. The findings were:<br><br>1. Interview with RNs #2 and #6 on 4/27/11 at 6:48 PM revealed resident #17 developed a dry, cracked area on the left heel on 4/1/11, but they were unsure if it was a pressure ulcer. RN #2 stated she identified the wound as a pressure ulcer on 4/3/11. According to the 2/16/11 admission MDS assessment, the resident was at risk for developing pressure ulcers but had intact skin at that time. Detailed review of the medical record showed no evidence the facility completed a significant change MDS assessment after identifying the pressure ulcer. On 4/28/11 at 9:16 AM, the MDS coordinator stated a significant change assessment had not been completed as the resident was "...leaving this weekend."<br><br>2. Medical record review showed a significant change MDS assessment was required for resident #52 due to the identification of a stage 3 pressure ulcer on 4/8/11. Review of the daily | F 274 | change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of resident's health status, and requires interdisciplinary review or revision of the care plan or both).<br>**Corrective Action:**<br>Resident #17 has been discharged from the facility.<br>Resident #52 has had a significant change of condition assessment completed.<br>**Identification of Others:**<br>MDS Coordinator/Designee to review nurses notes for the past 30 days to determine if a significant change of status assessment is needed. Those identified will be scheduled with ARD's and completed within 14 days of the identification.<br>**Systemic Changes:**<br>Residents with newly identified pressure ulcers will be reviewed for significant changes in morning business meeting and the IDT will determine if a significant change of condition is needed. The ARD will be set within 14 days if the IDT determine a significant change of status assessment is warranted. | |

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| F 274 | Continued From page 4<br>resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation, and staff interview, the facility failed to ensure a significant change MDS assessment was completed for 2 of 3 sample residents (#17, #52) who required this type of assessment. The findings were:<br><br>1. Interview with RNs #2 and #6 on 4/27/11 at 6:48 PM revealed resident #17 developed a dry, cracked area on the left heel on 4/1/11, but they were unsure if it was a pressure ulcer. RN #2 stated she identified the wound as a pressure ulcer on 4/3/11. According to the 2/15/11 admission MDS assessment, the resident was at risk for developing pressure ulcers but had intact skin at that time. Detailed review of the medical record showed no evidence the facility completed a significant change MDS assessment after identifying the pressure ulcer. On 4/28/11 at 9:16 AM, the MDS coordinator stated a significant change assessment had not been completed as the resident was "...leaving this weekend."<br><br>2. Medical record review showed a significant change MDS assessment was required for resident #52 due to the identification of a stage 3 pressure ulcer on 4/8/11. Review of the daily | F 274 | The MDS Coordinator will be in serviced by the Regional Clinical Director/Designee on the completion of a significant change of status assessment within 14 days of the identification of the significant change with reference to the RAI manual pages 2-12 and 2-16 through 2-21 including the guidelines for completing a significant change in status MDS assessment.<br>The NHA/Designee will review the assessment schedule weekly to determine the completion timeliness of any identified significant change of condition assessments.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>NHA/Designee to track and trend assessment timeliness and report findings to the QA & A committee monthly. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance monthly for 3 months then re-assess the need for continued monitoring based on compliance. | |

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| | 535026 | A. BUILDING _____ B. WING _____ | C 04/28/2011 |

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

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| F 274 | Continued From page 5<br>nurses' notes from 3/31/11 to 4/7/11 showed the resident did not have prior skin breakdown. Based on the 14 day requirement, the significant change assessment was due on 4/22/11. Interview with the MDS coordinator on 4/27/11 at 3:05 PM revealed a significant change was required but was not initiated. | F 274 | F 279<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.<br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 438.25 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10.<br>**Corrective Action:**<br>Resident # 6 comprehensive plan of care has been updated to include care plans for communication interventions/approaches, cognition | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to develop care plans for 2 of 18 sample residents (#6, #52) that included all areas identified as concerns for the | F 279 | | 6/6/11 |

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| F 279 | Continued From page 6<br>residents. The findings were:<br><br>1. According to the 3/21/11 admission MDS assessment, resident #6 was assessed as needing a care plan that included identified concerns with communication, impaired cognition, delirium, and mood state. Review of the care plan developed from this assessment showed these areas were not addressed. On 4/27/11 at 2:45 PM, RN #6 confirmed the care plan was current but failed to address the aforementioned areas.<br><br>2. Refer to F314 for details related to lack of a comprehensive care plan to prevent pressure ulcers for resident #52. | F 279 | interventions/approaches, delirium history interventions/approaches and mood interventions/approaches.<br>Resident #52 comprehensive plan of care has been updated to include pressure ulcer actual and risks and nutritional interventions/approaches.<br>**Identification of Others:**<br>An audit of the most recent Care Area Assessment (CAA) for the last 60 days will be conducted.<br>All CAA's will be compared to care plan and updated to reflect the assessment of the resident.<br>**Systemic Changes:**<br>The Interdisciplinary team will be in serviced on or before the date of compliance by the DON/designee concerning updating care plans with CAA review upon admission, change of condition and annually.<br>The MDS Coordinator/Designee will complete a random weekly audit of comprehensive assessments to ensure care plans are updated to reflect CAA (Care Area Assessment).<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the MDS | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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.<br><br>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. | F 280 | | 6/6/11 |

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| F 279 | Continued From page 6<br>residents. The findings were:<br><br>1. According to the 3/21/11 admission MDS assessment, resident #6 was assessed as needing a care plan that included identified concerns with communication, impaired cognition, delirium, and mood state. Review of the care plan developed from this assessment showed these areas were not addressed. On 4/27/11 at 2:45 PM, RN #6 confirmed the care plan was current but failed to address the aforementioned areas.<br><br>2. Refer to F314 for details related to lack of a comprehensive care plan to prevent pressure ulcers for resident #52. | F 279 | Coordinator/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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<br><br>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. | F 280 | F 280<br>The resident has the right unless judged incompetent or otherwise found to be incapacitated under the laws of the state , to participate in care planning care and treatment or changes in care and treatment.<br>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 legal representative; and periodically | 6/6/11 |

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| F 280 | Continued From page 7<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to revise the care plan for 1 of 18 sample residents (#6) to ensure it reflected the care and services currently required by the resident. The findings were:<br><br>According to the current care plan, resident #6 required only set-up assistance for meals, received physical and occupational therapy for rehabilitation, was to be reminded to ask for assistance, wore blue foam heel float boots, and received a recreational activity program and physical/occupational therapies for rehabilitation and to help control pain.<br>Observations on 4/25/11 at 6:20 PM and on 4/26/11 at 9:10 AM showed the resident required extensive to total assistance with meals. Further observation throughout the survey showed the resident remained in bed, but was not wearing blue foam heel float boots. Attempts to converse with the resident revealed s/he did not answer questions appropriately. Review of the 4/3/11 psychological evaluation revealed the resident displayed severe cognitive impairment. Medical record review confirmed the resident no longer received physical and occupational therapies.<br>On 4/27/11 at 3 PM RN #6 verified the care plan had not been revised to reflect the resident's current status and care requirements. | F 280 | reviewed and revised by a team of qualified persons after each assessment.<br>**Corrective Action:**<br>Resident #6 comprehensive plan of care as been revised and updated to include a communication care plan identified needs/interventions and approaches, reflection of level assist needed during meals, status of the blue foam boots and the discontinuance of OT and PT services.<br>**Identification of Others:**<br>A record review of resident's receiving a quarterly, annual or significant change of condition assessment in the last 30 days was conducted to determine the need for care plan revisions. All resident's receiving an assessment within this time period will have care plans reviewed by the IDT for revision.<br>**Systemic Changes:**<br>The Interdisciplinary team will be in serviced on or before the date of compliance by the DON/designee concerning updating care plans and revisions as needed, quarterly, annual and with change of condition. | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of | F 312 | The Interdisciplinary team will review telephone orders, the 24 hour report, incident and accidents each business day during the morning business meeting and revise care | 6/6/11 |

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| F 280 | Continued From page 7<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to revise the care plan for 1 of 18 sample residents (#6) to ensure it reflected the care and services currently required by the resident. The findings were:<br><br>According to the current care plan, resident #6 required only set-up assistance for meals, received physical and occupational therapy for rehabilitation, was to be reminded to ask for assistance, wore blue foam heel float boots, and received a recreational activity program and physical/occupational therapies for rehabilitation and to help control pain.<br>Observations on 4/25/11 at 6:20 PM and on 4/26/11 at 9:10 AM showed the resident required extensive to total assistance with meals. Further observation throughout the survey showed the resident remained in bed, but was not wearing blue foam heel float boots. Attempts to converse with the resident revealed s/he did not answer questions appropriately. Review of the 4/3/11 psychological evaluation revealed the resident displayed severe cognitive impairment. Medical record review confirmed the resident no longer received physical and occupational therapies.<br>On 4/27/11 at 3 PM RN #6 verified the care plan had not been revised to reflect the resident's current status and care requirements. | F 280 | plans as needed.<br>The Interdisciplinary team will review care plans during systems meetings for needed revisions.<br>The MDS Coordinator/Designee will verify that care plan revisions have been completed during care conferences quarterly, annually and with change of condition.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the MDS Coordinator/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance for 3 months. | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of | F 312 | F 312<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good | 6/6/11 |

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| F 312 | Continued From page 8<br>daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide adequate incontinence (perineal) care for 2 of 4 non-sample residents (#11, #34) who were dependent on staff for completion of perineal care. The findings were:<br><br>1. Observation on 4/26/11 at 6:35 PM showed resident #11 was incontinent of urine, and CNAs #8 and #4 provided incontinence care. While CNA #4 supported the resident with a sit-to-stand lift, CNA #8 stood behind the resident and reached between his/her legs to cleanse the perineum and buttocks. However, the CNA failed to cleanse the resident's anterior groin. Immediately after the observation, the CNA confirmed the resident had been incontinent of urine and that she failed to cleanse all skin surfaces in contact with urine<br><br>2. Observation of resident #34 on 4/26/11 at 7:55 AM showed CNAs #10 and #1 failed to cleanse the resident's anterior perineum after s/he was found to be incontinent of urine. Review of the 3/15/11 significant change MDS assessment revealed the resident required extensive assistance with personal hygiene. Interview with CNA #7 on 4/27/11 at 10:25 AM revealed she would cleanse an incontinent resident from front to back of the perineum. Further, she would cleanse the back of the residents' legs and lower | F 312 | nutrition, grooming and personal and oral hygiene.<br>**Corrective Action:**<br>Resident #8 has received peri care on 4/28/11 after initial observation and ongoing.<br>Resident #34 has received peri care on 4/28/11 after initial observation and ongoing.<br>**Identification of Others:**<br>A review of documentation of residents requiring assistance with peri care will be completed by DON/designee.<br>**Systemic Changes:**<br>DON/Designee will complete weekly random observations of peri care and review with IDT at morning meeting Monday through Friday.<br>SDC/designee will provide education on or before the date of compliance for all licensed staff on providing proper peri care.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the DON/designee.<br>The QA & A committee will evaluate | |

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| F 312 | Continued From page 9<br>back. Interview with the DON on 4/27/11 at 2 PM revealed the expectation for incontinence care also included cleansing the front of the legs and lower abdominal/groin area. | F 312 | the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. | |
| F 314 SS=E | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to either develop individualized preventive measures or provide adequate monitoring for 3 of 5 sample residents (#6, #17, #52) who developed pressure ulcers. The findings were:<br><br>1. Observation on 4/26/11 at 7 AM with RN #2 and physical therapist #13 showed resident #52 had an open ulcer on the coccyx that was covered with a dressing containing a minimal amount of serosanguinous drainage. Per RN #2, the wound measured 1 cm by 0.08 cm with yellow slough covering the base, and a small amount of granulation tissue was present around the edges of the wound. Review of the medical record face sheet showed the resident was admitted on 3/31/11 with diagnoses that included congestive | F 314 | **F-314 – Plan of Correction**<br>**Corrective Action:** Resident #52 was re-assessed for skin integrity issues. No new areas of compromise were identified. The IDT reviewed and revised the care plan to ensure it was comprehensive. The physician was notified, new orders received and interventions implemented as indicated. Family/responsible party was notified of changes. Resident #17 has discharged from the facility. Resident #6 was re-assessed for skin integrity issues. No new areas of compromise were identified. The IDT reviewed and revised the care plan to ensure it was comprehensive. The physician was notified, new orders received and interventions implemented as indicated. Family/responsible party was notified of changes.<br>**Identification of others:** The facility completed a head to tow skin assessment on facility residents to identify residents with compromised skin integrity. Residents identified with pressure ulcers were reviewed by the Interdisciplinary team. Physicians were notified, orders received and interventions implemented as indicated. | 6/6/11 |

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| F 314 | Continued From page 10<br>heart failure, anemia, and chronic obstructive pulmonary disease. Review of the interim care plan dated 3/31/11 showed the resident did not have actual skin breakdown or a history of pressure ulcers at the time of admission. However, the interim care plan showed a generalized problem for the potential for skin breakdown. The goal was to have the resident's skin remain intact. The interim care plan further showed generalized, non-specific interventions of "weekly" skin checks and to turn and reposition the resident "frequently." Review of the 3/31/11 and 4/7/11 Braden Scale (a tool used to determine pressure ulcer risk) scores showed the resident was at mild risk for developing pressure ulcers, with a score of 15. These Braden scale assessments showed the resident was chair-bound, his/her skin was occasionally moist, and friction and shear were potential problems. The following concerns were identified:<br>a. Review of the interim care plan showed there was no individualized repositioning plan, or a plan to address the resident's potential for skin shear or exposure to moisture. In addition, there was no specific plan to educate the resident and family regarding the need for repositioning and pressure-relieving devices.<br>b. Review of the 4/9/11 pressure ulcer care plan developed after the identification of the stage 3 pressure ulcer documented repositioning the resident in bed and the wheelchair would be done "frequently." The plan for positioning remained non-specific and not individualized even after this resident developed a pressure ulcer.<br>2. Review of the facility's program, "Skin Care Management," revised 6/2007, showed "Each resident receives the care and services necessary to retain or regain optimal skin | F 314 | Resident care plans were reviewed, revised and updated to ensure they are comprehensive. Changes to the care plans were communicated to care staff. Family/responsible party were notified of changes.<br>**Systemic Changes:** Residents will have a Braden Scale completed on admission, weekly for an additional three weeks, then quarterly, annually or with a significant change of condition. Ahead to toe assessment will be completed upon admission and weekly. Skin integrity issues will be documented on the pressure ulcer record or non-pressure ulcer record as appropriate. Residents with pressure ulcers will be reviewed weekly by the interdisciplinary team to determine progress of healing, evaluation of interventions. Physicians will be notified as indicated and orders/treatments changed as needed. Care plans developed upon admission will be reviewed and revised weekly as needed. Family/responsible party will be notified of changes. Changes to the care plan will be communicated to the care staff as they occur. A nutritional evaluation will be completed within 7 days of admission on residents identified at risk or with compromised skin integrity. A registered dietician will assess residents identified with skin impairment for nutritional status in | |



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| F 314 | Continued From page 11<br>integrity...is evaluated by the interdisciplinary team to determine his or her risk for skin compromise or the presence of wounds and/or pressure ulcers...If skin compromise occurs, evaluation is conducted...to ensure appropriate measures are in place to minimize further compromise and aid in healing..." The document stated: "All residents will be checked from "head to toe" weekly by a licensed nurse," the nurse "will document the results of weekly skin checks in the resident's medical record." When an ulcer was identified, the nurse was to document in the progress notes and on the "Weekly Pressure Ulcer Record" to include the "size, stage, location, drainage, odor, and pain...and notification of interdisciplinary wound team..." The nurse was to document "daily monitoring of all pressure ulcers to include status of the dressing, surrounding skin, presence of possible complications, and pain using the "Daily Monitoring Pressure Ulcer Record..." The following concerns with failure to implement this program were noted:<br>a. Observation on 4/26/11 at 11:05 AM showed resident #17 had a pressure ulcer on the left heel. According to the 2/5/11 admission nursing assessment, the resident had intact skin when admitted with a fractured ankle. Review of documentation in the 2/16/11 admission MDS assessment showed the facility assessed the resident as being at risk for developing pressure ulcers. Detailed medical record review showed weekly skin checks were not documented between 3/20 and 4/17/11. Review of a nursing note dated 4/2/11 showed the resident had an intact dressing "to PU [pressure ulcer] on L [left] heel" and was wearing bilateral heel protectors. Further review of the nursing notes showed no prior information regarding the development of | F 314 | a timely manner. Communication of new areas of compromised skin integrity will be documented on the 24-hour report. DON/Designee will review the 24 hour report and new telephone orders each business day and follow up to ensure appropriate assessments are completed, orders and treatments are on the MAR/TAR. The IDT will track the progress of residents with compromised skin integrity through the weekly Care Management Risk Review meeting. During weekly wound rounds the IDT will ensure that the interventions are in place, care planned and still appropriate. The DON/Designee will re-educate the licensed nurses on the Skin Management system. Re-education will include weekly skin checks, Braden scale, nutritional evaluation, proper interventions including support surfaces, required documentation in the medical record, care plans, communication to physician, resident and resident's family/responsible party. Inservices will be completed on or before the date of compliance.<br>**Monitor:** The DON/Designee will review the head to toe skin assessments, MAR's/TAR's, pressure ulcer and non-pressure ulcer records weekly to ensure compliance. The DON/designee will attend the weekly care management review meeting for | |

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| | 535028 | A. BUILDING _____ B. WING _____ | C 04/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SHERIDAN MANOR | 1051 BIG HORN AVE SHERIDAN, WY 82801 |

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| F 314 | Continued From page 12<br>the pressure ulcer. On 4/27/11 at 6:48 PM, interview with RNs #2 and #6 revealed that on 4/1/11 the resident's left heel was dry and had developed what looked like a "linear fissure" or crack in the skin. Review of the treatment record and the verbal orders confirmed the physician was notified, a dressing was applied that day, and foam boots were implemented. Registered nurse #2 stated she did not determine the area to be a pressure ulcer until 4/3/11. However, the facility's skin care program was not implemented as described below.<br>i. The medical record lacked evidence the licensed nurse documented the results of the weekly skin checks. During the aforementioned interview on 4/27/11, both RNs confirmed the record lacked descriptions of the skin checks from 3/20/11 until 4/17/11, a time period of four weeks. | F 314 | skin management to monitor residents identified with skin integrity issues and to ensure compliance with the skin management system. The DON/designee will review results of the weekly monitoring of the skin management system components and the care management review skin management meeting for patterns and trends. The patterns and trends will be reported monthly to the QA&A committee. The QA&A committee will evaluate the results and implement additional interventions as needed to ensure continued compliance. | |
| F 332 SS=E | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and staff interview, the facility failed to maintain a medication error rate of less than 5 percent (%). Out of 71 opportunities for errors, 6 errors were committed resulting in an error rate of 8.45%. The residents affected by the errors were non-sample residents #2, #23, #38 and #42. The findings were: | F 332 | | 6/6/11 |

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| F 314 | Continued From page 12<br>the pressure ulcer. On 4/27/11 at 6:48 PM, interview with RNs #2 and #6 revealed that on 4/1/11 the resident's left heel was dry and had developed what looked like a "linear fissure" or crack in the skin. Review of the treatment record and the verbal orders confirmed the physician was notified, a dressing was applied that day, and foam boots were implemented. Registered nurse #2 stated she did not determine the area to be a pressure ulcer until 4/3/11. However, the facility's skin care program was not implemented as described below.<br>I. The medical record lacked evidence the licensed nurse documented the results of the weekly skin checks. During the aforementioned interview on 4/27/11, both RNs confirmed the record lacked descriptions of the skin checks from 3/20/11 until 4/17/11, a time period of four weeks. | F 314 | | |
| F 332 SS=E | 483.25(m)(1).FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, observation and staff interview, the facility failed to maintain a medication error rate of less than 5 percent (%). Out of 71 opportunities for errors, 6 errors were committed resulting in an error rate of 8.45%. The residents affected by the errors were non-sample residents #2, #23, #38 and #42. The findings were: | F 332 | **F 332**<br>The facility must ensure that it is free of medication error rates of 5% or greater.<br>**Corrective Action**<br>Resident #23 medication Zenpep is being given 15 minutes before meals.<br>Resident #38 Tobramycin eye drops are being administered as ordered two drops each dose.<br>Resident #42 Meloxicam is being given and scheduled time and Iron is being given with meals.<br>Resident #2 has specified doses clarified with the physician for Fish Oil and Potassium Chloride. | 6/6/11 |

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| F 332 | Continued From page 13<br>1. On 4/26/11 at 5:21 PM, RN #12 was observed to administer medications, including Zenpep, to resident #23 who was eating the evening meal. Reconciliation of the medication pass showed the physician specifically ordered the medication to be administered fifteen minutes before the meal. On 4/26/11 at 4:22 PM the RN acknowledged she administered the medication incorrectly.<br><br>2. On 4/26/11 at 7 PM, LPN #5 was observed administering Tobramycin eye drops to resident #38, one drop in each eye. Reconciliation of the medication with the physician's orders showed the physician ordered two drops in each eye. Interview with RN #11 on 4/26/11 at 2:25 PM revealed two drops in each eye were to be given.<br><br>3. On 4/26/11 at 7:20 AM, RN #11 was observed giving resident #42 meloxicam and iron. Reconciliation of the medications with the physician's orders showed meloxicam was to be given at 9 AM, instead of 7:20 AM. The iron was ordered to be given with meals; breakfast was not served until 8:30 AM, 1 hour and 10 minutes after the medication was administered. Interview with the RN on 4/26/11 at 2:25 PM confirmed the medication was to be given as ordered.<br><br>4. Observation on 4/26/11 showed RN #9 prepared and administered medications for resident #2 at 7:46 AM. The medications included 1000 milligrams (mg) of fish oil and 99 mg of potassium chloride. Reconciliation of the medications showed the physician did not specify the dosage for either medication; however, he did authorize that potassium chloride be OTC (over the counter). Review of information faxed by the pharmacist on 4/26/11 revealed both these | F 332 | **Identification of Others:**<br>Nurse managers and DON will observe 4 nurses completing a medication pass to ensure residents receive medications per physician order. Any errors will be written on a medication variance report and 1:1 education will be provided by the DON/Designee.<br>**Systemic Changes:**<br>In service education was provided to licensed by the SDC/designee on Medication Pass utilizing the facilities medication administration policy.<br>DON/Designee will conduct weekly random audits for one month and monthly random audits for 3 months to ensure that nurses are properly following the 5 rights when administering medication.<br>Immediate education will be provided if facility Medication Administration Policy is not appropriately followed.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>Data obtained by way of audit will be reviewed and analyzed for pattern and trends and reported monthly to the facility QA & A committee by | |

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| F 332 | Continued From page 14<br>medications were manufactured in varying dosages. Although the pharmacist had identified the problem with dosages on 4/22/11, interview with the DON on 4/26/11 at 2:30 PM confirmed it had not been corrected before the observation on 4/26/11. Two errors occurred during this medication pass. | F 332 | DON/Designee. Patterns will also be addressed during the facility Medication Management and Administration Committee quarterly as needed. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. | 6/6/11 |
| F 363 SS=E | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of the menu spreadsheet, the facility failed to ensure the planned amount of food was served for 5 of 6 residents (#16, #23, #43, #53, #57) whose meal preparations were observed during service. The findings were:<br><br>Observation of the evening meal on 4/26/11 showed cook #16 had prepared bread stuffing to be served with the main meal. According to the menu spreadsheet, the portion planned for the stuffing was a #8 scoop (equivalent to 1/2 cup). During the meal service observation at 5:02 PM, dietary aide #14, who was preparing to serve the meals, verified the scoop sizes being used. Observation showed 4 regular meals were served to residents #16, #23, #43 and #57. Each one was provided a portion from a #10 sized scoop | F 363 | | |



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| F 332 | Continued From page 14<br>medications were manufactured in varying dosages. Although the pharmacist had identified the problem with dosages on 4/22/11, interview with the DON on 4/26/11 at 2:30 PM confirmed it had not been corrected before the observation on 4/26/11. Two errors occurred during this medication pass. | F 332 | | |
| F 363 SS=E | 483.35(a) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of the menu spreadsheet, the facility failed to ensure the planned amount of food was served for 5 of 6 residents (#15, #23, #43, #53, #57) whose meal preparations were observed during service. The findings were:<br><br>Observation of the evening meal on 4/26/11 showed cook #16 had prepared bread stuffing to be served with the main meal. According to the menu spreadsheet, the portion planned for the stuffing was a #8 scoop (equivalent to 1/2 cup). During the meal service observation at 5:02 PM, dietary aide #14, who was preparing to serve the meals, verified the scoop sizes being used. Observation showed 4 regular meals were served to residents #15, #23, #43 and #57. Each one was provided a portion from a #10 sized scoop | F 363 | **F 363**<br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of National Research Council, National Academic of Sciences; be prepared in advance; and be followed.<br>**Corrective Action:**<br>Resident #15 is being served meals with the proper scoop size.<br>Resident #23 is being served meals with the proper scoop size.<br>Resident #43 is being served meals with the proper scoop size.<br>Resident #53 is being served meals with the proper scoop size.<br>Resident #57 is being served meals with the proper scoop size.<br>Meals are being served to all residents as posted unless approved by RD in writing.<br>**Identification of Others:**<br>All menus will be reviewed by Registered Dietician, Dietary Manager and Dining Staff for scoop size and content. | 6/6/11 |

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| F 363 | Continued From page 15<br>(equivalent to 2/5 cup) instead of the planned 1/2 cup. In addition, the menu spreadsheet showed 3/4 cup of vegetable soup was planned; none was prepared or served. Interview with the cook on 4/26/11 at 4:43 PM revealed no soup was prepared because it was too much food and would overwhelm the residents. There was nothing in writing to show that this change had been approved by the dietitian or the CDM. Interview with the CDM on 4/27/11 at 10:20 AM revealed the menu should be followed unless a change was approved in advance.<br><br>Observation of the pureed meal that was served for resident #53 showed the planned menu was not followed. The resident was served a #8 scoop (1/2 cup) of pureed turkey, stuffing and gravy mixture, a #12 scoop (1/3 cup) of pureed vegetables, and a #8 scoop (1/2 cup) of mashed potatoes in place of the pureed bread stuffing. The planned menu showed the resident should have received a #8 scoop, equivalent to 6 ounces, of pureed soup, two #8 scoops (1 cup total) of pureed hot turkey sandwich, and a # 8 scoop (1/2 cup) of bread stuffing. Interview with the CDM on 4/27/11 at 10:20 AM revealed her expectation was that the menu be followed. | F 363 | **Systemic Measures:**<br>Education will be provided to dining staff on or before the date of compliance regarding scoop sizes, the importance of following the recommended scoop sizes and following the posted menu.<br>The Registered Dietician will review the menus on a monthly basis and approve any changes in writing prior to the meal being served.<br>The Dietary Manager will conduct random audits weekly to ensure menus are being followed and appropriate scoop sizes are being used.<br>The Registered Dietician will conduct and audit twice per month to ensure menus are being followed and appropriate scoop sized are being used.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary. Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee will evaluate effectiveness of the plan based on trends identified and implement | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | 6/6/11 |

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| F 363 | Continued From page 15<br>(equivalent to 2/5 cup) instead of the planned 1/2 cup. In addition, the menu spreadsheet showed 3/4 cup of vegetable soup was planned; none was prepared or served. Interview with the cook on 4/26/11 at 4:43 PM revealed no soup was prepared because it was too much food and would overwhelm the residents. There was nothing in writing to show that this change had been approved by the dietitian or the CDM. Interview with the CDM on 4/27/11 at 10:20 AM revealed the menu should be followed unless a change was approved in advance.<br><br>Observation of the pureed meal that was served for resident #63 showed the planned menu was not followed. The resident was served a #8 scoop (1/2 cup) of pureed turkey, stuffing and gravy mixture, a #12 scoop (1/3 cup) of pureed vegetables, and a #8 scoop (1/2 cup) of mashed potatoes in place of the pureed bread stuffing. The planned menu showed the resident should have received a #8 scoop, equivalent to 6 ounces, of pureed soup, two #8 scoops (1 cup total) of pureed hot turkey sandwich, and a # 8 scoop (1/2 cup) of bread stuffing. Interview with the CDM on 4/27/11 at 10:20 AM revealed her expectation was that the menu be followed. | F 363 | additional interventions as needed to ensure continued compliance monthly for 3 months. | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | F 371<br><br>The facility must<br>(1) Procure from sources approved or considered satisfactory by Federal, State, or local authorities; and<br>(2) Store, Prepare, Distribute and serve food under sanitation condtions | 6/6/11 |



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| F 371 | Continued From page 16<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure cooking equipment was in good condition, that appropriate handwashing techniques were used and that a ceiling vent in the clean dish storage area was clean. The findings were:<br><br>1. The initial kitchen observation on 4/25/11 at 3 PM showed 8 full sized metal baking sheets were in poor condition, having black and rusty colored corrosion. The corrosion was around the edges of the outsides of the pans. In addition, there were 5 color coded cutting boards that were stained deeply and scored from use. Interview with the CDM at that time revealed the pans were "many years old." The CDM verified these pans and the cutting boards were used in the kitchen daily and needed to be replaced. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (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.<br><br>2. Observation on 4/25/11 at 3 PM and on 4/26/11 at 4:10 PM showed a ceiling vent located in the clean side of the dish room that was positioned in a way that the clean dishes stored in the room on shelving could be contaminated by | F 371 | **Corrective Action:**<br>Eight Full sized metal baking sheets were replaced.<br>Five color coded cutting boards were replaced on 4/27/11.<br>The ceiling vent was cleaned and is free of dust and grease on 4/27/11<br>Dining staff are using proper hand washing when coming in contact with anything that could soil them. The unlabeled nail brush was disposed of on 4/26/11.<br>**Identification of Others:**<br>The dietary manager has reviewed all sanitation audits for the last 30 days to ensure cleaning and storage of any identified areas has been completed.<br>**Systemic Changes:**<br>Dietary Manager will re-educate dining staff on or before the date of compliance to include training on sanitation assignments, proper cleaning techniques after use of equipment, proper labeling and storage of nail brush and proper hand washing techniques.<br><br>Dietary Manager will complete sanitation checks each business day to ensure proper cleaning and storage.<br>Dietary Manager/designee will randomly observe hand washing weekly to ensure proper technique is being used. | |



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| F 371 | Continued From page 17<br>the grease and dust visible on the vent. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."<br><br>3. During meal service preparation on 4/26/11 at 4:55 PM observation showed dietary aides #14 and #15 were pouring creamer into individual portion cups with lids. At that time the aides had clean hands and were not wearing gloves. However, when the creamer ran out, aide #14 went to the walk-in refrigerator to retrieve another carton. The aide handled the walk-in refrigerator door with her bare hands and then, without any hand hygiene, she opened the creamer carton with her soiled hands and proceeded to portion out the creamer. Interview with the CDM on 4/27/11 at 10:20 AM revealed staff were taught to clean their hands after coming in contact with anything that could soil them. According to Food Code 2009, U.S. Public Health Service, 2-301.11 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands<br><br>d. Observation on 4/25/11 at 3 PM showed an unlabeled nail/hand brush sitting on the handwashing sink. Interview with the CDM on 4/27/11 at 10:20 AM revealed she was not sure who used the nail/hand brush. According to Food Code 2009, U.S. Public Health Service, Annex 3- | F 371 | NHA/Designee to complete random observations of kitchen sanitation on a monthly basis.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary. Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. | |



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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 04/28/2011 |

| 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 371 | Continued From page 18<br>Public Health Reasons / Administrative Guidelines: 2-301.12 Cleaning Procedure: "Fingernail brushes, if used properly, have been found to be effective tools in decontaminating this area of the hand. Proper use of single-use fingernail brushes, or designated individual fingernail brushes for each employee, during the handwashing procedure can achieve up to a 5-log reduction in microorganisms on the hands." | F 371 | | |
| F 514 SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure physician progress notes were filed as part of the medical record for 10 of 15 sample residents (#1, #6, #10, #15, #17, #18, #25, #53, #60, #87). The findings were:<br><br>Review of the medical records showed physician progress notes were lacking for the following | F 514 | **F 514**<br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systemically organized.<br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any pre-admission screening conducted by the state; and progress notes.<br>**Corrective Action:**<br>A current progress note has been completed and placed in the clinical record for resident #1.<br>A current progress note has been completed and placed in the clinical record for resident #6.<br>A current progress note has been completed and placed in the clinical record for resident #10. | 6/6/11 |

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| F 514 | Continued From page 19<br>residents: #1, #6, #10, #15, #17, #18, #25, #53, #60, #87 . Interview with the medical records director on 4/27/11 at 11:30 AM revealed she was behind on getting the physician progress notes transcribed and included in the resident records. She also stated there were notes that had been transcribed but were not filed. She revealed that some of the notes needing to be included in the medical records were dated as far back as August 2010 | F 514 | A current progress note has been completed and placed in the clinical record for resident #15.<br>Resident #17 has been discharged from the facility.<br>A current progress note has been completed and placed in the clinical record for resident #18.<br>A current progress note has been completed and placed in the clinical record for resident #25.<br>A current progress note has been completed and placed in the clinical record for resident #53.<br>A current progress note has been completed and placed in the clinical record for resident #60.<br>A current progress note has been completed and placed in the clinical record for resident #87.<br>**Identification of Others:**<br>An audit was completed on 5/25/11 by Medical Records Director/Designee, to determine those residents who have a missing progress note filed on the clinical record. A current progress note was placed in all clinical records identified.<br>**Systemic Changes:**<br>The Director of Nursing and/or designees will conduct random audits of resident clinical records weekly to ensure that a current progress note is complete and filed on the clinical | |

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|---|---|---|---|---|
| F 514 | Continued From page 19<br>residents: #1, #8, #10, #15, #17, #18, #25, #53, #60, #87 . Interview with the medical records director on 4/27/11 at 11:30 AM revealed she was behind on getting the physician progress notes transcribed and included in the resident records. She also stated there were notes that had been transcribed but were not filed. She revealed that some of the notes needing to be included in the medical records were dated as far back as August 2010 | F 514 | record.<br>The Medical Records Director will complete the transcription within seven days of receiving the recording from the attending physician and file the typed progress note on the clinical record.<br>The Medical Record Director/designee will file progress notes in the clinical record within seven days of receipt.<br>**Monitor:**<br>The Quality Assessment and Assurance Committee meets monthly to address noted trends and patterns through a number of clinical and operations systems as necessary.<br>Trends and patters obtained from weekly audits will be analyzed by the Director of Nursing and the result of such analysis will be discussed at the Quality Assessment and Assurance Committee meeting monthly. The Committee will make recommendations for changes as necessary. The Committee will continue to monitor physician progress notes for three months and then as necessary. | |