| 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 09/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHERIDAN MANOR | 1551 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 |
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| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey was conducted by Healthcare Licensing and Surveys on 9/11/17 through 9/14/17. The complaint survey was prompted by complaint intakes WY00002308, WY00002322, and WY00002462.<br><br>The following common abbreviations are used throughout this document:<br><br>CNA- Certified Nurse Aide<br>DON- Director of Nursing<br>LPN- Licensed Practical Nurse<br>MDS- Minimum Data Set<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 253 SS=E | 483.10(l)(2) HOUSEKEERING & MAINTENANCE SERVICES<br><br>(l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and resident and staff interview, the facility failed to ensure a safe and sanitary environment in 4 of 5 hallways (100 hall, 300 hall, 400 hall, 500 hall). The findings were:<br><br>Observation on 9/13/17 at 9:50 AM and 5:15 PM, and on 9/14/17 at 8:35 AM revealed the following concerns:<br><br>1. Related to the 100 hall:<br>a. The green wall covering on the lower section of the walls in room numbers 108, 135, | F 253 | F 253<br>It is the practice of this facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior – specifically to ensure a safe and sanitary environment.<br><br>**Corrective Action:**<br>The green wall covering on the lower section of the walls in room numbers 108, 135, 136, 141 and 143 was removed and replaced by 10/29/2017 by the Maintenance Supervisor or designee.<br>The cove base around the perimeter of room 302, 308, 309, 311, bathroom of room 306, and bathroom of room 511 will be stripped of wax and dirt build up, cleaned and resealed or replaced | 10/29/17 DH |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deb Hall — TITLE: NHA — (X6) DATE: 10/29/17



RECEIVED POC accepted. Case to Derek Holbrook, NHA on 10/31/17 @ 8:36 a.m.
OCT 06 2017
Healthcare Licensing and Surveys
DOC - 10/29/17
Janelle

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| F 253 | Continued From page 1<br>136, 141, and 143 had numerous areas of various-sized bubbled surfaces.<br><br>2. Related to the 300 hall:<br>a. The cove base around the perimeter of room #302 had a buildup of wax and dirt. There was a gap between the floor tiles at the entrance to the bathroom which contained an accumulation of dirt and debris and could not be effectively cleaned.<br>b. The bathroom floor in room #308 was discolored and stained, had a 1 3/4 by 1/2 inch rust-colored gouge underneath the foot of the toilet riser, and two cracks one (measured 4 inches and the other 8 inches) located near the base of the wall across from the toilet.<br>c. The cove base around the perimeter of room #308 and #309 was discolored with a buildup of wax and dirt.<br>d. In room #311 there was a piece of blue tape 31 inches long and 2 inches wide on the floor at the entrance to the bathroom which was peeled up on the edges and contained an accumulation of dirt and debris. The cove base around the perimeter of the room was discolored with a buildup of wax and dirt.<br>e. The floor in room #314 was discolored with multiple rust-colored areas of various sizes underneath and beside the chest of drawers.<br>f. In room #316 there was a 1/2 inch gap between the floor tiles at the entrance to the bathroom which contained an accumulation of dirt and debris and could not be effectively cleaned.<br>g. The floor around the perimeter of the secure unit activity room and throughout the 300 hallway had a buildup of dirt and debris.<br><br>3. Related to the 400 hall:<br>a. In room #408 the edge of the bathroom | F 253 | by 10/29/2017 by Housekeeping Supervisor or designee.<br>The blue tape in room 311 will be removed and the gap in room 316 were both replaced with a low profile threshold flooring transition at the entrance of the bathroom by10/29/2017, by Maintenance Supervisor or designee.<br>The floor around the perimeter of the secure unit activity room and throughout the 300 hallway will be stripped of wax, debris and dirt buildup and resealed by 10/29/2017 by Housekeeping Supervisor or designee.<br>The edge of the bathroom door in room 406 was repaired by 10/29/2017 by Maintenance Supervisor or designee.<br>The floor tiles in room 314, the bathroom of room 415 in the center of the hallway between room 407 and 409, and between 409 and 411, and between 411 and 413, room 502, 504 and 506 will be stripped of wax, dirt and debris buildup, cleaned, and cracks and gouges individually sealed by 10/29/2017 by Housekeeping supervisor or designee.<br>The ceiling tiles in room 502 which were warped and damaged will be repaired by a contracted repair company by 10/28/2017 with oversight by Maintenance Director. | 10/29/17 DH |

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| F 253 | Continued From page 2<br>door, on the hinge side, was broken with splintered edges 24 inches from the floor. The exposed wood had been wrapped with tape. Interview with resident #14 revealed s/he had suffered a cut between the knuckles of his/her right hand coming out of the bathroom. The kick plate on the interior surface of the bathroom door was broken and exposed sharp edges.<br>b. The bathroom floor in room #416 had three 22 inch long non-skid strips located in front of the toilet. The strip closest to the toilet had a 4 inch section which had peeled up and contained an accumulation of dirt and debris.<br>c. The floor in the center of the hallway between room #407 and #409 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>d. The floor in the center of the hallway between room #409 and #411 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>e. The floor in the hallway between room #411 and #413 contained eighteen 12 by 12 inch tiles with cracks which spanned the width of the hall.<br><br>4. Related to the 500 hall:<br>a. There were 20 ceiling tiles in room #502 which were warped and damaged. The floor was discolored and stained throughout the room.<br>b. The floor in room #504 was discolored and stained throughout the room.<br>c. The floor, on the window side of room #508, had nine 12 by 12 inch tiles which contained multiple gouges of various sizes.<br>d. In room #511 there were 2 gouges in the wall near the bathroom; one was 34 inches from the floor and was visible for 6 inches and then continued behind a chest of drawers; the second | F 253 | The wall in room 511 with gouges present, interior bathroom door frame damage, bathroom wall gouges will be repaired by 10/29/2017 by Maintenance Director or designee.<br>The bathroom door in room 511 which contained splintered and exposed sharp edges will be repaired by 10/29/2017 by Maintenance Director or designee.<br><br>**Identification of Others:**<br>An audit will be conducted by the NHA or designee by 10/15/2017 of resident rooms with wall coverings on the lower section of the walls with bubbles surfaces.<br>An audit will be conducted by the NHA or designee of cove base and flooring in resident rooms and common areas throughout the facility by 10/15/2017.<br>An audit will be conducted by the NHA or designee of ceiling tile, walls and doors throughout the facility by 10/15/2017<br>All audit findings will be reported to the QAPI committee for further planning and scheduling with plans for correction/completion. | 10/29 DH |

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| F 253 | Continued From page 2<br>door, on the hinge side, was broken with splintered edges 24 inches from the floor. The exposed wood had been wrapped with tape. Interview with resident #14 revealed s/he had suffered a cut between the knuckles of his/her right hand coming out of the bathroom. The kick plate on the interior surface of the bathroom door was broken and exposed sharp edges.<br>b. The bathroom floor in room #416 had three 22 inch long non-skid strips located in front of the toilet. The strip closest to the toilet had a 4 inch section which had peeled up and contained an accumulation of dirt and debris.<br>c. The floor in the center of the hallway between room #407 and #409 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>d. The floor in the center of the hallway between room #409 and #411 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>e. The floor in the hallway between room #411 and #413 contained eighteen 12 by 12 inch tiles with cracks which spanned the width of the hall.<br><br>4. Related to the 500 hall:<br>a. There were 20 ceiling tiles in room #502 which were warped and damaged. The floor was discolored and stained throughout the room.<br>b. The floor in room #504 was discolored and stained throughout the room.<br>c. The floor, on the window side of room #506, had nine 12 by 12 inch tiles which contained multiple gouges of various sizes.<br>d. In room #511 there were 2 gouges in the wall near the bathroom; one was 34 inches from the floor and was visible for 6 inches and then continued behind a chest of drawers; the second | F 253 | **Systemic changes:**<br>Facility staff, including contracted housekeeping personnel, will be educated by the Maintenance Supervisor as to the work order request process by 10/29/2017.<br>The Maintenance Supervisor will be educated on the preventative maintenance program by the Nursing Home Administrator or designee by 10/29/2017.<br>The Maintenance Supervisor will bring work order requests to department head stand up meeting for review daily. | 10/29 DH |

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| F 263 | Continued From page 2<br>door, on the hinge side, was broken with splintered edges 24 inches from the floor. The exposed wood had been wrapped with tape. Interview with resident #14 revealed s/he had suffered a cut between the knuckles of his/her right hand coming out of the bathroom. The kick plate on the interior surface of the bathroom door was broken and exposed sharp edges.<br>b. The bathroom floor in room #415 had three 22 inch long non-skid strips located in front of the toilet. The strip closest to the toilet had a 4 inch section which had peeled up and contained an accumulation of dirt and debris.<br>c. The floor in the center of the hallway between room #407 and #408 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>d. The floor in the center of the hallway between room #409 and #411 contained cracks that radiated in a spider web pattern in twenty 9 by 9 inch tiles.<br>e. The floor in the hallway between room #411 and #413 contained eighteen 12 by 12 inch tiles with cracks which spanned the width of the hall.<br><br>4. Related to the 500 hall:<br>a. There were 20 ceiling tiles in room #502 which were warped and damaged. The floor was discolored and stained throughout the room.<br>b. The floor in room #504 was discolored and stained throughout the room.<br>c. The floor, on the window side of room #508, had nine 12 by 12 inch tiles which contained multiple gouges of various sizes.<br>d. In room #511 there were 2 gouges in the wall near the bathroom; one was 34 inches from the floor and was visible for 6 inches and then continued behind a chest of drawers; the second | F 263 | **Ongoing Monitoring:**<br>The Maintenance Supervisor will identify and report a summary of work orders, including trends to the Quality Assessment Performance Improvement (QAPI) committee.<br>The Maintenance Supervisor and/or Nursing Home Administrator will conduct random environmental rounds of 4 resident rooms weekly for 4 weeks, then 2 resident rooms weekly for 8 weeks. The Maintenance Supervisor will review the random rounds, identify any deficient practice and trends and report to the Quality Assessment Performance Improvement (QAPI) committee monthly for 3 months to validate compliance. The MS and NHA will subsequently conduct random environmental rounds in 1 of 4 subsections of the facility interior and 2 random resident rooms monthly thereafter until a lesser frequency has been deemed appropriate. | 10/29 DH |

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| F 253 | Continued From page 3<br>one was 38 inches from the floor and was 3 inches long. Inside the bathroom the cove base had pulled away from the wall and contained a buildup of dirt and debris. A 12 inch long section of wall on the interior doorframe of the bathroom was chipped and exposed the underlying metal. A 2 by 3 inch section of wall was damaged and exposed the underlying drywall. The interior of the bathroom door had a 4 inch long broken section, 11 inches from the floor, which was splintered and exposed sharp edges. There were three gouges in the bathroom wall underneath the towel rack; one was 9 inches long and 37 inches from the floor, the second was 1 1/2 by 1/2 inch and the third was 1/2 by 1/2 inch.<br><br>Tour and interview with the maintenance director on 9/14/17 at 8:35 AM confirmed the issues with building damage and cleanliness and verified they needed to be cleaned or repaired. | F 253 | | 10/29 DH |
| F 278 SS=E | 483.20(g)-(l) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. | F 278 | **F 278**<br>It is the practice of this facility to ensure the MDS assessment accurately reflected the status of residents – specifically to update with accurate heights/weights, significant incidents and changes of condition, and accurate skin assessments and treatments.<br><br>**Corrective Action:**<br>Resident #25 had a completed quarterly MDS assessment by 10/8/2017 to accurately reflect a fall incident.<br>Resident #70, 71, 3, 40 will have a quarterly MDS assessment completed by 10/8/2017 to accurately capture the residents' height and weight.<br>Resident #81 will have a quarterly MDS assessment completed by 10/8/2017 to accurately reflect status of skin condition and fall incident. A head to toe skin assessment Resident #81 will be completed by 10/8/2017.<br>Care plans, physician orders and treatments were updated as necessary by 10/8/2017. | |

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| F 278 | Continued From page 4<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) 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<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure the MDS assessment was accurate for 6 of 19 sample residents (#3, #25, #40, #70, #71, #81). The findings were:<br><br>1. Review of the quarterly MDS assessment with an assessment reference date (ARD) of 8/8/17 showed resident #25 had no falls since the previous assessment. However, review of the medical record showed the resident had a fall on 8/28/17 which resulted in a laceration to the scalp. During an interview on 9/14/17 at 11:18 AM the DON confirmed the resident's fall on 8/28/17 and stated the MDS was not accurate related to falls.<br><br>2. Review of MDS assessments revealed the following inaccuracies for height/weight data: | F 278 | | |

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| F 278 | Continued From page 6<br>a. Review of the 6/13/17 significant change and the 8/29/17 quarterly MDS assessments showed data was not included related to height for resident #70.<br>b. Review of the 6/30/17 annual MDS assessment showed data was not included related to height for resident #71.<br>c. Review of the 6/8/17 significant change and 8/8/17 quarterly MDS assessments showed data was not included related to weight for resident #3.<br>d. Review of the 6/21/17 annual MDS assessment showed resident #40 had no height entered.<br>e. Interview with the registered dietitian on 9/13/17 at 4:40 PM verified the height and weight information was lacking in these instances and the issue was being worked on to ensure accuracy.<br><br>3. Review of the 7/20/17 admission MDS showed resident #81 was admitted with 2 venous or arterial ulcers. Review of the 8/8/17 quarterly MDS assessment showed resident #81 had not fallen since the prior assessment and had two stage 2 pressure ulcers which were present on admission with the most severe tissue type coded as granulation. The following concerns were identified:<br>a. Review of the weekly skin assessments from the time of admission showed no evidence the resident had pressure ulcers.<br>b. Review of a nurse's note dated 7/29/17 showed the resident had fallen in the dining room when s/he had attempted to walk to the table without his/her walker.<br><br>Interview on 9/13/17 at 5:15 PM with the DON and the consultant nurse verified the resident did | F 278 | **Identification of Others:**<br>An audit will be conducted by the MDS Coordinator for MDS coding accuracy related to coding of falls, skin, height and weight on the MDS completed in the past 30 days by 10/15/2017 with corrections made related to the audit findings<br>All audit findings will be reported to the QAPI committee for further planning and scheduling for correction/completion.<br><br>**Systemic Measures:**<br>All residents will receive an accurate MDS assessment upon admission, quarterly, annually and with a significant change of condition. Residents will receive accurate and timely updates to care plans, physician orders and treatments as necessary following changes in skin condition, falls and other significant events.<br>The DON or designee will educate IDT and nursing staff on resident assessments, care plans, incident reporting process and weekly skin assessments by 10/29/2017. | 10/29 DH |

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| F 278 | Continued From page 5<br>a. Review of the 8/13/17 significant change and the 8/29/17 quarterly MDS assessments showed data was not included related to height for resident #70.<br>b. Review of the 6/30/17 annual MDS assessment showed data was not included related to height for resident #71.<br>c. Review of the 5/8/17 significant change and 8/9/17 quarterly MDS assessments showed data was not included related to weight for resident #3.<br>d. Review of the 8/21/17 annual MDS assessment showed resident #40 had no height entered.<br>e. Interview with the registered dietitian on 9/13/17 at 4:40 PM verified the height and weight information was lacking in these instances and the issue was being worked on to ensure accuracy.<br><br>3. Review of the 7/20/17 admission MDS showed resident #81 was admitted with 2 venous or arterial ulcers. Review of the 8/8/17 quarterly MDS assessment showed resident #81 had not fallen since the prior assessment and had two stage 2 pressure ulcers which were present on admission with the most severe tissue type coded as granulation. The following concerns were identified:<br>a. Review of the weekly skin assessments from the time of admission showed no evidence the resident had pressure ulcers.<br>b. Review of a nurse's note dated 7/29/17 showed the resident had fallen in the dining room when s/he had attempted to walk to the table without his/her walker.<br><br>Interview on 9/13/17 at 5:15 PM with the DON and the consultant nurse verified the resident did | F 278 | **Monitoring:**<br>The MDS Coordinator or designee will conduct random audits of 3 MDS assessments for coding accuracy weekly for 4 weeks, then monthly for 2 months to validate continued compliance. The audit results will be reported by the MDS Coordinator to monthly QAPI meetings.<br>The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for four months then reassess the need for continued monitoring based on compliance. | 10/29 DM |

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| F 278 | Continued From page 6<br>not have pressure ulcers and had fallen since the last MDS assessment. In addition, they confirmed the MDS was inaccurately coded. | F 278 | **F 280**<br>It is the practice of this facility to ensure that residents' comprehensive care plans are revised as necessary and related to significant changes of condition and significant incidents. | 10/29 DH |
| F 280 SS=D | 483.10(c)(2)(I-II,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(I) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(II) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(I) Facilitate the inclusion of the resident and/or resident representative. | F 280 | **Corrective Action:**<br>The care plan for resident #22 was revised on 9/13/2017 by the MDS Coordinator to accurately reflect the resident transfer status and electronic alarm.<br>The care plan and physician orders will be updated by the DON or designee by 10/8/2017 to accurately reflect the transfer status and placement or removal of the electronic alarm.<br><br>**Identification of Others:**<br>An audit will be conducted by the DON or designee by 10/29/2017 of resident transfer status and electronic alarms to validate accurate care plans.<br><br>**Systemic Measures:**<br>Upon admission, quarterly and with significant change of condition, the direct care nursing staff will complete a transfer assessment and residents will be evaluated for use of an electronic alarm. Nursing Department | |

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| F 280 | Continued From page 7<br>(II) Include an assessment of the resident's strengths and needs.<br><br>(III) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(I) Developed within 7 days after completion of the comprehensive assessment.<br><br>(II) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. | F 280 | staff will ensure resident care plans are updated in a timely manner.<br>The DON or designee will educate nursing staff and IDT regarding care plan and kardex accuracy for residents transfers and alarms use by 10/29/2017.<br><br>**Monitoring:**<br>The DON or designee will audit 5 care plans per week for 4 weeks, then 5 care plans per month for 2 months related to resident transfers and alarm use. Corrective action will be taken as necessary for any identified concerns. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly or three months then reassess the need for continued monitoring based on compliance. | 10/29 DH |

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| F 280 | Continued From page 8<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure care plans were revised for 1 of 18 sample residents (#22) reviewed. The findings were:<br><br>1. Review of the care plan for resident #22 in the category of falls, last revised on 8/8/17, showed the resident required the assistance of 1 staff member to safely transfer between surfaces and an electronic alarm was to be applied to his/her wheelchair. The following concerns were identified:<br>a. Observation on 9/12/17 at 9:20 AM showed the resident self-transferred from his/her wheelchair into a recliner with no staff present. An electronic alarm was not present on the wheelchair.<br>b. Observation on 9/12/17 at 5 PM showed the resident self-transferred from his/her wheelchair into a recliner with no staff present. An electronic alarm was not present on the wheelchair. At that time CNA #1 checked the kardex (brief synopsis of information for each resident) and confirmed the resident was to have an alarm on the wheelchair. Interview with LPN #1 at 5:17 PM revealed the resident did not like the alarm and would take it off and leave it in various locations in the building.<br>c. Interview on 9/13/17 at 4:47 PM with the DON and the consultant nurse confirmed the care plan had not been updated. | F 280 | | |

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| F 371<br>F 371<br>SS=F | Continued From page 9<br>483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(I) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(II) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(III) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(l)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure food and equipment was stored and prepared under sanitary conditions in 3 of 3 food storage/preparation areas (the kitchen/dish room/dry storage, secure unit dining room, activity room). The findings were:<br><br>1. Observation in the kitchen on 9/13/17 at 11:25 AM showed cook #1 was finished preparing pureed vegetables. The cook placed the food on | F 371<br>F 371 | F 371<br>It is the practice of this facility to ensure food and equipment is stored and prepared under sanitary conditions in food storage/preparation areas.<br><br>**Corrective Action:**<br>Cook #1 and all dietary staff will be educated on proper food and equipment storage and preparation under sanitary conditions, specifically on: appropriate food temperatures and food temperature documentation, proper hand washing and proper glove use by 10/29/2017 by the District Dietary Manager.<br>Shelving was stripped, gouges and scrapes individually sealed and the complete shelving units resealed to ensure cleanable and sanitary surface on 10/29/2017 by the Maintenance Supervisor or designee.<br>The microwaves throughout the facility were cleaned of any dried-on food and debris on 10/8/2017 to ensure clean and sanitary condition by the Dietary Manager or designee.<br>The metal shelf with rust present and the ledge with crumbling white material will be removed and replaced with a new shelving material by 10/29/2017 by the Maintenance Supervisor. | 10/29<br>DH |

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| F 371 | Continued From page 10<br>the steam table getting ready for the meal service. The cook failed to take the temperature of the food. When asked about the temperatures, the cook measured the various food items and the pureed vegetable (110 degrees F) and pasta (120 degrees F) were found to be below the required temperature of 135 degrees F. The food items were then re-heated. At 12:04 PM steam table 2 which contained food for the secure unit residents was transferred to that unit. Server #1 began serving the food and when asked if the temperatures of the foods were taken she stated she had not taken the temperatures, she thought the cook had done so. Interview with the cook at 12:13 PM revealed the temperatures of the food for steam table 2 were not taken. The interview revealed there was no system established to take temperatures of the food on steam table 2 prior to service.<br><br>2. Observation in the kitchen on 9/13/17 at 11:32 AM showed dietary aide #1 was preparing to work with food. The aide handled the walk-in refrigerator door and without washing her hands donned gloves and continued to work with clean equipment portioning out food into cups.<br><br>3. Observation in the dry storage room on 9/11/17 at 4:15 PM showed multiple shelving units that were composed of solid wooden shelves. These units contained at least 60 shelves that were used to store food and clean supplies. The shelves had worn varnished/painted surfaces, and were damaged with gouges and scrapes making them non-cleanable.<br><br>4. Observation of the 2 microwaves located in the activity room on 9/12/17 at 9:12 AM and on 9/13/17 at 11:04 AM showed the microwaves | F 371 | The edges of the floors in the kitchen/dish room and dry storage area, along with the steamer unit and carts, will be cleaned of dirt and build-up of debris by 10/29/2017by the Dietary Manager or designee.<br><br>**Identification of Others:**<br>All facility residents have the potential to be affected by the practice of storing, preparing, distributing and serving food under sanitary conditions.<br><br>**Systemic Measures:**<br>The Dietary Manager or designee will educate all dietary staff to ensure food temperature documentation, proper hand washing, proper glove use, floor and equipment cleaning schedules are maintained by 10/29/2017. Newly hired dietary staff will be educated during orientation.<br>The NHA or designee will audit the food temperature logs, floor and equipment cleaning schedules, proper food storage, preparation, distribution and services under sanitary condition weekly for 4 weeks. | 10/29 DH |

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| F 371 | Continued From page 11<br>were soiled with dried-on food debris. In addition, on 9/12/17 at 9:28 AM the microwave in the secure unit dining room was observed to be soiled with dried-on food and debris.<br><br>5. Observation on 9/11/17 at 4:15 PM and on 9/13/17 at 11:04 AM showed the following unclean/damaged areas:<br>a. A metal shelf in the dish room was corroded with rust. The rust was eating through the shelf and the shelf was being used to store racks for sending dishes through the dish machine.<br>b. A ledge located at the opening from the dirty to clean side of the dish room was damaged with loose and crumbling white material.<br>c. The edges of the floors in the kitchen/dish room and dry storage area had a build-up of dirt and debris. In addition, the wheels on the moveable equipment (steamer unit and carts) in the kitchen were soiled with a build-up of grease and dirt.<br><br>6. Interview with the district dietary manager and the facility kitchen manager on 9/13/17 at 3:36 PM revealed the shelving units and other damaged areas were in need of replacement/repair, and the staff were expected to wash hands when soiled and prior to gloving. Further, the two managers verified there was a need to develop a system to take and record the food temperatures prior to service, and the cleaning in the secure unit dining room and the activity room needed to be assigned and better communicated to ensure completion.<br><br>7. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and | F 371 | **Monitoring:**<br>The Dietary Manager or designee will conduct random audits of food temperature logs, flooring and equipment cleaning and cleaning schedule documentation, food storage, preparation, distribution and service under sanitary conditions weekly for 4 weeks, then monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. The Dietary Manager will report the finding and trends to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance. | 10/29 DH |

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| F 371 | Continued From page 12<br>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>8. 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."<br><br>9. According to Food Code 2013, U.S. Public Health Service 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C ) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above"<br><br>10. According to the National Restaurant Association Servsafe Coursebook 5th edition, pg 11-9 Dry Storage: "Shelving, table tops, and bins for dry ingredients should be made of corrosion-resistant metal or food-grade plastic." | F 371 | F 425<br><br>It is the practice of this facility to provide routine and emergency drugs and biologicals in order to meet the needs of each resident – specifically to ensure expired medications were not available for resident use.<br><br>**Corrective Action:**<br>The insulin flex pens observed open without an open date were discarded on 10/8/2017 by the Director of Nursing or designee.<br><br>**Identification of Others:**<br>All facility residents have the potential to be affected by the practice. Medication carts and medication cabinet storage units were audited by the DON or designee on 10/8/2017 to ensure the removal of insulin flex pens open without an open date.<br><br>**Systemic Measures:**<br>The facility will ensure to label individual insulin pens with an open date and store unopened insulin pens and all medication in accordance with manufacturers' guidelines.<br>The DON or designee will educate nursing staff on the proper storage and labeling of medications by | 10/29 PH |
| F 425 SS=E | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES; RPH<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. | F 425 | | |

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| F 425 | Continued From page 13<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and review of manufacturer's instructions, the facility failed to ensure expired medications were not available for use in 3 of 5 medication carts (Chapel hall, Courtyard hall, Rock Creek hall). The findings were:<br><br>1. Observation of the medication carts showed the following:<br>a. Chapel hall on 9/13/17 at 10:09 AM showed 8 insulin flex pens that were open and available for residents use without an open date written on them.<br>b. Courtyard hall on 9/13/17 at 10:46 AM showed 1 insulin flex pen that were open and available for residents use without an open date written on it.<br>c. Rock Creek hall on 9/13/17 at 11:24 AM showed 1 insulin flex pen that were open and available for residents use without an open date written on it.<br><br>2. Interview on 9/13/17 at 11:24 AM with LPN #2 revealed she was unsure of how many days the flex pen could be used once taken out of the refrigerator. She also stated that the flex pens would be used to give the residents their insulin injections.<br><br>3. Review of the manufacturer's instructions | F 425 | 10/29/2017. Newly hired nursing staff will be educated during orientation.<br><br>**Monitoring:**<br>The DON or designee will audit the medication carts for the proper storage and labeling of insulin pens weekly for 4 weeks, then monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns.<br>The DON will report the finding and trends to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance. | 10/29 DH |

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| F 425 | Continued From page 14<br>stated under the storage instructions, once the insulin is taken out of cool storage, for use or as a spare, you can use it for up to 28 days. Do not use it after this time. | F 425 | | 10/29 |
| F 441 SS=E | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | F 441 | F 441<br><br>It is the practice of this facility to ensure infection prevention and control practices are implemented – specifically the proper cleaning and disinfection of glucometers.<br><br>**Corrective Action:**<br>All glucometers in the facility were cleaned and disinfected by the DON or designee by 10/8/2017.<br><br>**Identification of Others:**<br>The glucometers in use throughout the facility had the potential to be affected by the deficient practice.<br><br>**Systemic Measures:**<br>The facility will ensure the proper cleaning and disinfection of glucometers in accordance with manufacturers' guidelines.<br>The DON or designee will educate nursing staff on the proper cleaning and disinfection of glucometers and responsibilities and assignments by 10/10/2017. Newly hired nursing staff will be educated during orientation. | |

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| F 441 | Continued From page 16<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, policy review, and review of manufacturer's instructions, and Centus for Disease Control guidelines, the facility failed to ensure infection prevention practices were implemented during 4 random observations. The findings were: | F 441 | **Monitoring:**<br>The DON or designee will audit the glucometer cleaning and disinfection assignments and observe when in use by nursing staff 5 times weekly for 4 weeks, then monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. The DON will report the audit findings and trends monthly to the QAPI committee. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance. | 10/29 DH |

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| F 441 | Continued From page 16<br><br>1. Observation on 9/12/17 at 10:49 AM showed RN #1 was in room 404 taking a blood sugar test with a glucometer. She walked out of the room, set the glucometer down on the medication cart, and gathered supplies for another finger-stick. She then went into room 407 and was observed performing a resident's glucose reading. She repeated this process with residents in room 403 and 401. She returned to the medication cart and set the glucometer on top of the medication cart. At 11:28 AM she placed the glucometer back in the medication cart. Throughout the observations she did not disinfect the glucometer.<br><br>2. During an interview on 9/12/17 at 11:18 AM RN #1 stated "No we do not clean the glucometer between uses, they are cleaned nightly with bleach wipe and calibrated."<br><br>3. During an interview on 9/13/17 at 10:23 AM RN #2 stated they clean the glucometer with alcohol wipes because there were no bleach wipes on the carts.<br><br>4. During an interview on 9/13/17 at 10:46 AM RN #3 stated they clean the glucometer with alcohol wipes between uses.<br><br>5. On 9/13/17 at 4 PM the corporate consultant nurse provided the facility's policy titled "Cleaning and Disinfecting Glucometers Training/Tracking" revised October 2012, which showed the "Glucometer's are to be cleaned with the Super Sani-Cloth Germicidal wipe..., monitor must stay wet for 2 minutes."<br><br>6. Review of the manufacturer's instructions for the Evencare G2 meter showed "Cleaning and | F 441 | | 10/29 DH |

| 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 09/14/2017 |

| 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 441 | Continued From page 17<br>disinfecting the meter and lancing device is very important in the prevention of infectious disease. The following products are validated for disinfecting the EvenCare G2 Meter: * Diapatch Hospital Cleaner Disinfectant Towels with Bleach * Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol * Clorox Healthcare Bleach Germacidal and Disinfectant Wipes * Medline Micro-Kill Bleach Germacidal Bleach Wipes...Other EPA Registered wipes may be used for disinfecting the EvenCare G2 system, however, these wipes have not been validated and could affect the performance of the meter. "<br><br>7. Review of Centus for Disease Control recommendations entitled "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" retrieved from www.cdc.gov/injectionsafety/blood-glucose-monitoring.html on 9/14/17 showed "...blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions..." | F 441 | | 10/29 DR |