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 01/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 1/16/2018 to 1/19/18. The survey was prompted by complaint intakes WY000002551 and WY000002552.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/3/18

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

Electronically Signed | 02/11/2018

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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F 656	Continued From page 1 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow the care plan for 2 of 7 sample residents (#4, #7) regarding bath and shower preferences. The findings were: 1. Review of bath and shower documentation showed resident #4 received a bath or shower on 1/2/18. The next bath or shower was documented on 1/12/18 (10 days). Review of the care plan revealed the following requirements initiated on 6/2/16: "Bathing/Showering: [Resident's name] needs supervision with set up assistance of 1 Provider to complete shower 1-3 times per week. [Resident's name] has decreased ROM to [his/her] shoulders and will need help with [his/her] back and lower extremities. Be aware of [his/her] toes and make sure to keep them clean and dry." The plan was revised during the survey on 1/17/18 to add, "[Resident's name] often refuses [his/her] shower." The review revealed no documented refusals or explanation as to why the facility failed to provide the resident with a bath or shower from 1/3/18 until 1/12/18. 2. Review of the bath and shower documentation showed resident #7 received a bath or shower on 12/3/17. The next bath or shower was	F 656	F-656 It is the standard of this facility that sufficient nursing staff is provided to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident per their care plan. Corrective Action: Resident #4 will be interviewed by 02/16/18 for bathing preferences; the care plan will be updated to included preferences, approaches, and alternate interventions for refusals. Resident # 7 will be interviewed by 02/16/18 for bathing preferences; the care plan will be updated to included preferences, approaches, and alternate interventions for refusals. Identification of Others: A facility sweep was conducted on 01/31/18 to interview each resident of their shower/bath preferences, days and times. Care plans and Kardex will be updated by 02/23/18 to included	

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F 656	Continued From page 2 documented on 12/18/17 (15 days). Further review showed the resident received a bath or shower on 12/28/17 and the next bath or shower was documented on 1/7/18 (10 days). Review of the care plan revealed the following requirements with a target date of 12/19/17: "Bathing/Showering: The resident is totally dependent on 1 staff to provide shower 2-3 times per week as necessary." The review revealed no documented refusals or explanation as to why the facility failed to provide the resident with a bath or shower from 12/4/17 until 12/18/17, or from 12/29/17 until 1/7/18. 3. Interview with the corporate nurse on 1/18/18 at 11:30 AM confirmed it was her expectation for all residents to receive baths and showers as per their care plan.	F 656	preferences, approaches, and alternate interventions for refusals. Systemic Measures: The facility plans to ensure their resident care plans accurately reflect shower/bath preferences, approaches, and alternate interventions for refusals. IDT will review all current residents shower/bath logs for completed documentation of bathing provided and/or refusals 5X per week, weekend logs will be reviewed on Monday. During Ambassador rounds, if issues or concerns regarding the showers are expressed by a Resident, a Resident concern form will be filled out. The form will be forwarded to the Administrator and /or DON immediately. The concern will be investigated with a resolution and proper documentation completed. The SDC or designee will educate nursing department staff on bathing preference, offering alternate bathing options, documentation of refusals, care plans and Kardex by 03/03/18. Monitoring: The DON and/or designee will audit the daily bathing documentation and/or refusal, and care plan accuracy for 10 residents 2 X per week for 4 weeks and monthly for 3 months. The DON will report the audit findings at the monthly QAPI meeting for review and further recommendations.	

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and family interview, the facility failed to ensure showers/baths were completed in a timely manner for 3 of 7 sample residents (#4, #7, #8). The findings were: 1. Medical record review showed resident #4 had diagnoses which included non-Alzheimer's dementia. Review of the 12/13/17 annual MDS assessment showed the resident required assistance of one staff member for baths and showers. Review of bath and shower documentation showed the resident received a bath or shower on 1/2/18, and the next bath or shower was documented on 1/12/18 (10 days). The review revealed no documented refusals or explanation as to why the facility failed to provide the resident with a bath or shower from 1/3/18 until 1/12/18. 2. Medical record review showed resident #7 had diagnoses which included depression and seizure disorder. Review of the 12/7/17 admission MDS assessment showed the resident required total assistance of one staff member for baths and showers. Review of the bath and shower documentation showed the resident received a bath or shower on 12/3/17, and the next bath or shower was documented on 12/18/17 (15 days). Further review showed the resident received a bath or shower on 12/28/17 and the next bath or	F 677	F-677 It is the standard of this Facility that ADL Care Provided for Dependent Resident are revised as necessary and related to each resident□s preference. Corrective Action: Resident #4 will be interviewed by 02/16/18 for bathing preferences and frequency. The care plan will be updated to included preferences, approaches, alternate interventions for refusals. Resident #7 will be interviewed by 02/16/18 for bathing preferences and frequency. The care plan will be updated to included preferences, approaches, alternate interventions for refusals. Resident #8 will be interviewed by 02/16/18 for bathing preferences and frequency. The care plan will be updated to included preferences, approaches, alternate interventions for refusals. Identification of Others: A facility sweep was conducted on 01/31/18 to interview each resident of	3/3/18

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F 677	Continued From page 4 shower was documented on 1/7/18 (10 days). The review revealed no documented refusals or explanation as to why the facility failed to provide the resident with a bath or shower from 12/4/17 until 12/18/17, or from 12/29/17 until 1/7/18. 3. Medical record review showed resident #8 had diagnoses which included peripheral vascular disease and arthritis. Review of the 11/10/17 quarterly MDS assessment showed the resident required assistance of one staff member for baths and showers. Review of the bath and shower documentation showed the resident received a bath or shower on 11/10/17, and the next bath or shower was documented on 11/28/17 (18 days). The review revealed no documented refusals or explanation as to why the facility failed to provide the resident with a bath or shower from 11/11/17 until 11/28/17. 4. Interview on 1/17/18 at 9:30 AM with CNA's #1 and #2 revealed the facility did not routinely assign bath aides, and sometimes baths or showers did not get done for residents in a timely manner due to staffing issues. 5. Interview with family member #1 on 1/17/18 at 7:01 PM confirmed s/he sometimes had to tell facility staff his/her resident was overdue for a bath or shower in order for the resident to receive a bath or shower. 6. Interview with the corporate nurse on 1/18/18 at 11:30 AM confirmed it was her expectation for all residents to receive baths and showers in a timely manner.	F 677	their shower/bath preferences and frequency. Care plans and Kardex will be updated to included preferences, frequency, approaches, and alternate interventions for refusals by 02/23/18. Systemic Measures: The facility plans to ensure their resident care plans accurately reflect shower/bath preferences, frequency approaches, and alternate interventions for refusals. IDT will review all current residents shower/bath logs for completed documentation of bathing provided and/or refusals 5X per week, weekend logs will be reviewed on Monday. During Ambassador rounds, if issues or concerns regarding the showers are expressed by a resident, a Resident concern form will be filled out. The form will be forwarded to the Administrator and /or DON immediately. The concern will be investigated with a resolution and proper documentation completed. The SDC or designee will educate nursing department staff on bathing preference, offering alternate, bathing option, documentation of refusals, care plans, and Kardex by 03/03/18. Monitoring: The DON and/or designee will audit the daily bathing documentation and/or refusal, and care plan accuracy for 10 residents 2 X per week for 4 weeks and monthly for 3 months.	

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F 677	Continued From page 5	F 677	The DON will report the audit findings at the monthly QAPI meeting for review and further recommendations.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medical record review, 2017 Facility Assessment review, daily staff posting review, staff schedule review, QA & A Log review,	F 725	F-725 sufficient nursing staff. Staffing will be maintained according to Facility Assessment Plan.	3/3/18

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F 725	Continued From page 6 grievance review, resident council meeting minutes review, resident interview, staff interview, and family interview, the facility failed to ensure adequate nurse aide staffing for 57 of 61 days reviewed. The findings were: Review of the "2017 Facility Assessment" showed the facility's estimation of nurse aide staffing requirements according to the staffing plan at section 3.B was: "Each unit is staffed with a Charge Nurse, 2 C.N.A. [sic], except for the Rock Creek Unit has 2 Nurses and 3 CNA's or 2 CNA's and a RA (Resident Care Specialists), which are non-medically certified Resident Assistants..." Review of staff schedules showed the facility had 4 nursing units: Chapel, Courtyard, Deer Lane, and Rock Creek. The following concerns were identified: a. Review of the daily staff postings from 11/17/17 through 1/16/18 showed the CNAs were posted by number of CNAs and total hours for a 24 hour period. The review revealed the facility number of hours for CNAs failed to meet the minimum hours required by the 2017 Facility Assessment (# of CNA hours in 24 hours = 8 CNAs * 24 hours, or 192 CNA hours) for 57 of 61 days reviewed. b. Interview on 1/17/18 at 9:30 AM with CNA's #1 and #2 revealed the facility did not always complete baths and showers for residents in a timely manner due to staffing issues. They further stated staffing issues were worse on weekends and holidays. c. Interview with family member #1 on 1/17/18 at 7:01 PM confirmed s/he sometimes had to tell staff his/her resident required assistance with personal care such as incontinence and baths and showers, and s/he felt this was due to insufficient staffing.	F 725	Corrective Action: The facility will staff the nursing department based on the 2017 facility assessment plan daily. NHA and DON meet with Division Vice President of Clinical Services and District Director of Clinical Service on 01/31/18 to ensure staffing patterns align with the Facility Assessment Plan. Identification of Others: The NHA and DON will review the staffing schedule 1 X weekly for 1 month in advance to ensure the facility is staffed per the Facility Assessment Plan per census and acuity. Systemic changes: NHA, DON and scheduler will meet 5 x a week to discuss daily staffing and ensure the facility is staffed adequately based on the Facility Assessment Plan, census and resident acuity. Ongoing Monitoring: Short term schedule monitoring: NHA, DON and scheduler will meet 5 x a week to discuss daily staffing and ensure the facility is staffed adequately based on the Facility Assessment Plan, census and resident acuity.	

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F 725	Continued From page 7 d. Interview on 1/16/18 at 3:40 PM with resident #6 revealed staffing was sometimes insufficient on weekends and holidays, which caused a delay in required care. e. Interview with resident #9 on 1/17/18 at 1 PM revealed staffing was sometimes inadequate, which caused an extended delay before staff were available to get him/her out of bed. The resident also stated sometimes baths and showers were missed due to staffing. f. Review of bath and shower documentation revealed resident #4 received a bath or shower on 1/2/18, and the next bath or shower was documented on 1/12/18 (10 days). Review of the bath and shower documentation revealed resident #7 received a bath or shower on 12/3/17, and the next bath or shower was documented on 12/18/17 (15 days). Further review revealed the resident received a bath or shower on 12/28/17 and the next bath or shower was documented on 1/7/18 (10 days). Review of the bath and shower documentation revealed resident #8 received a bath or shower on 11/10/17, and the next bath or shower was documented on 11/28/17 (18 days). g. Review of the 10/21/17 Resident Council Meeting Minutes revealed the following documentation at "Any Concerns (completion of form)": "Call lights, bed making." Review of the 11/16/17 Resident Council Meeting Minutes revealed the following documentation at "Any Concerns (completion of form)": "Too long to answer call lights, Showers not getting done on scheduled days, but getting them." Review of the 12/21/17 Resident Council Meeting Minutes revealed the following documentation at "Any Concerns (completion of form)": "Not enough staff-Having Class in January." h. Review of the Concern QA & A Log revealed the following on 11/7/17: "[Resident #10]	F 725	Long term schedule monitoring: The NHA and DON will complete a weekly review of the staffing schedule for 1 month in advance to ensure the facility is staffed per the Facility Assessment Plan per census and acuity. The NHA will report both long and short term staffing outcomes at the monthly QAPI meeting for review and further recommendations.	

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F 725	Continued From page 8 waited 50 minutes for call bell." Review of the grievance documentation showed the resident stated there was improvement, and the facility would continue to monitor call lights. Further review of the Concern QA & A Log revealed the following on 12/13/17: "[Resident #11] states it took 4 hours for nurse to answer call bell." Review of the grievance documentation showed "things are improving." No specifics to address the concern were identified. Continued review of the Concern QA & A Log revealed the following on 12/22/17: "[Resident #12] has not had a shower." Review of the grievance documentation showed "things are getting better." No specifics to address the concern were identified. i. Interview with the corporate nurse and administrator on 1/18/18 at 11:30 AM confirmed there were 6 full-time CNA positions open. The administrator further stated the CNA class at the facility would have 6 graduates on the following Friday (1/26/18), and another CNA class was scheduled to start in early February 2018. The facility was actively attempting to hire the 1/26/18 graduates for full-time employment.	F 725		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		3/3/18

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F 732	Continued From page 9 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff posting review and staff interview, the facility failed to ensure data and posting requirements were followed concerning daily staff postings. The findings were: Observation of staff posting on 1/16/18 at 5 PM showed the posting was in a public area. Review of postings from 11/17/17 through 1/16/18 showed the postings were completed daily. Further review identified the following concerns: a. The review of staff postings from 11/17/17	F 732	F-732 Posted Nurse Staffing Information It is the practice of this facility to provide an accurate account daily of staffing and census. Corrective Action: The daily staff posting was corrected on 01/17/18. Identification of Others: The daily staff posting includes: Facility name, current date, the total number and	

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F 732	Continued From page 10 through 1/16/18 revealed the postings were completed once in 24 hours, and the facility failed to post the information separately for each shift. b. Continued review of the staff postings revealed the facility failed to include the daily census for 53 days out of 61 days reviewed (87%). c. Interview with the corporate nurse and administrator on 1/18/18 at 11:30 AM confirmed the daily staff postings were frequently missing the daily census, and the postings were being posted once per 24 hours and not once per shift.	F 732	actual hours worked by each category of staff (RN, LPN, CNA's) providing direct resident care, per shift and current census. Systemic changes: The NHA will provide educate for the scheduler and Manager on Duty for the weekend regarding accurate staffing posting requirements by 03/03/18. Ongoing Monitoring: The NHA or designee will audit the staff posting for accuracy 3 X weekly for 4 weeks and weekly for 2 months. The NHA will report the staff posting audit outcomes at the monthly QAPI meeting for review and further recommendations.	