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

PRINTED: 09/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 09/13/2018

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 recertification survey was conducted by Healthcare Licensing and Surveys from 9/10/18 through 9/13/18. Also reviewed in the course of the survey were complaint intakes WY00002623, WY00002650, and WY00002686. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F 550 **Corrective Action:** This event with resident #28 occurred in the past and has been addressed during survey observation. **Identification of others:** All residents have the potential to be affected. **Systemic Changes:** The DON or designee will educate all staff on maintaining resident's rights and dignity. Frequent rounding by the DON or designee will be implemented to include observation on ambassador rounds with documentation to include meeting resident's dignity and rights. CNA #7, RN #7, and RN #6 involved with resident #28 have been made aware of how dignity and the resident's rights were not met in this instance. Education will be provided to each employee involved by 10/16/2018. CNA #9 no longer works at the facility.	10/16/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Brown	Director of Nursing	10/5/2018

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.

this plan of correction was accepted with the agreed upon change on 10/12/18. Alexis Brown, DON was notified 10/12/18 at 3:52 PM. Jean Hennie RN (ASCP)

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, the facility failed to maintain resident dignity during 1 random observation that affected resident #28. The findings were: 1. Review of the quarterly MDS assessment with an assessment reference date (ARD) of 7/13/18 showed resident #28 had a BIMS score of 11 (indicating moderate cognitive impairment) and required extensive assistance with bed mobility, transfers, locomotion, and dressing. Observation on 9/10/18 beginning at 3:19 PM showed resident	F 550	**Ongoing Monitoring:** Frequent observations through ambassador rounds will be implemented to determine that resident's rights and dignity are maintained. Any concerns addressed through the observation process will be monitored and reported in summary in the facility monthly QAPI meeting. IDT will assess for trends or patterns during these meetings. 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.	

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F 550	Continued From page 2 #28 was in a wheelchair with his/her pants visibly wet on the inside of his/her legs. At 3:24 PM CNA #7 and CNA #9 used a mechanical lift and transferred the resident onto the bed. Staff performed incontinence care and CNA #7 identified a wound above a Coban (self-adherent wrap) wrapping on the resident's left leg at 3:32 PM. At that time, RN #7 entered the room, attempted to cover the resident, and stated the resident did not have a change of pants available. CNA #7 asked for the charge nurse to assess the left leg wound. The following concerns were identified: a. At 3:49 PM staff informed the resident s/he would have to remain in bed until they found some pants and the nurse to assess his/her leg. The resident verbalized s/he was upset about the wait. b. LPN #1 entered the room at 3:58 PM to discuss medications with the resident then left without providing care. The resident stated, "Please get me up, please, please." CNA #7 explained to the resident, "I just want the nurse to look at the wound above the Coban on the left leg before we get you dressed. The Coban is too tight, we need to do something." At that time CNA #7 yelled out of door, "I have asked for the nurse 3 times, where is she?" c. At 4:09 PM the resident started crying and stated, "I've been in here for an hour, I need to be up." d. At 4:21 PM, RN #8 cut off the Coban on the resident's lower legs. The RN cleaned the wound above where the Coban had been with wound cleanser, dressed the wound with a padded dressing, and then placed compression socks on the resident. e. At 4:29 PM RN #7 returned with a clean pair of pants, staff dressed the resident, and	F 550		

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F 550	Continued From page 3 placed the sling for the mechanical lift behind the resident. The resident stated, "I can't believe this, let's get the hell out of here. Get my ass out of here." f. Continued observations showed the resident was transferred to the wheelchair and a nasal cannula was placed on the resident at 4:38 PM, 1 hour and 19 minutes after care was initiated. 2. Interview with the resident on 9/13/18 at 9 AM revealed the care on 9/10/18 was "uncalled for" because the nurse took a long time and s/he stated "it upset me." 3. Interview with the DON on 9/12/18 at 1:47 PM confirmed the expectation was for the CNA to report to the nurse immediately and the nurse to respond as soon as possible.	F 550		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(	F 567	F 567 **Corrective Action:** Resident #40 was able to retrieve his money from the account upon request 9/11/2018. **Identification of Others:** Any resident who has a Resident Trust Fund maintained by the facility could be affected by current procedure.	10/16/2018

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F 567	Continued From page 4 l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure resident funds were readily available for 1 of 4 sample residents (#40) who maintained a funds account with the facility. The findings were: 1. Interview with resident #40 on 9/11/18 at 9:29 AM revealed the resident had a funds account at the facility, but the funds were only available from 8 AM to 4 PM Monday through Friday. 2. Interview with the social services director on 9/11/18 at 4:50 PM revealed residents were "allowed to get funds 7 AM to 11 AM" and the facility did not have a system in place to provide	F 567	**Systemic Change:** Resident fund manager or designee will ensure that funds are available for resident withdrawal within 24 hours of the request including weekend days. Education will be provided by resident fund manager or designee for weekend staff that are involved in banking process by 10/16/2018. **Ongoing Monitoring:** Resident fund manager or designee will conduct random audits weekly of those with resident trust accounts for 4 weeks and monthly for 2 months to verify that resident request to withdraw money are met within 24 hours including weekend days. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by the Resident Fund Manager in summary during the facility monthly QAPI meeting. NHA will assess for trends or patterns during these meetings. 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.	

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F 567	Continued From page 5 funds on the weekend.	F 567		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident representative, resident, and staff interview, and policy and procedure review, the facility failed to ensure resident account statements were provided to 3 of 4 sample residents (#7, #16, #81) who maintained funds at the facility. The findings were: 1. Interview with the representative for resident #81 on 9/11/18 at 2:19 PM revealed s/he received funds requests from the facility and provided funds for the resident to use. Further, it was revealed the representative had not received an account statement from the facility. 2. Interview with resident #7 on 9/11/18 at 9:34 AM revealed the resident had a personal funds account at the facility. Further, it was revealed the resident had not received an account statement from the facility.	F 568	F 568 **Corrective Action:** Resident or responsible party #7, #16, and #81 were offered and provided current RFMS statements on 9/12/2018. **Identification of Others:** All residents with RFMS accounts have the potential to be affected. **Systemic Change:** All residents with RFMS accounts were provided or offered current financial statements on 09/12/2018. District Director of Business Office Systems will educate Business Office Manager regarding RFMS account statements and distribution by October 16, 2018. Business Office Manager or designee will audit all residents with RFMS accounts for correct addresses to ensure statements are being delivered to the correct resident or responsible party. Business Office Manager or designee will ensure delivery of quarterly RFMS statements to residents within the facility. If an address change occurs, Business Office Manager or designee will ensure address is also changed on RFMS account.	10/16/2018

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F 568	Continued From page 6 3. Interview with the representative for resident #16 on 9/11/18 at 9:12 AM revealed the resident had a personal funds account at the facility. Further, it was revealed the representative had not received an account statement from the facility. 4. Interview with the business office manager on 9/13/18 at 9:49 AM revealed the facility received statements from the corporate office and sent them out to residents or family members. However, the facility did not have a system in place to ensure statements were received for all residents, and were sent to the appropriate location. Further, it was revealed the facility did not have a personal funds account set up for resident #81 and had the facility's address listed for resident #16 and resident #7. It was confirmed that resident #16 had a representative and the statement should be provided to the representative instead of the resident. 5. Review of the policy titled "Resident Trust Accounts" last revised 10/2017 showed "...Regulations...All resident cash must be posted into the Resident Trust Account. Cash is not to be kept in the safe for individual residents...Daily Requirements...4. Cash received for deposit must be witnessed by two employees, must have a completed receipt, and must have a money order purchased for the deposit amount...Quarterly Procedures...1. NDC creates quarterly statements and sends to Houston Office where they are printed and mailed. Facility copies are available on Reports Central. 2. Trust statements are distributed to residents who are presumed competent on a quarterly basis or upon their request. 3. Trust statements for residents who	F 568	**Ongoing Monitoring:** Business Office Manager or designee will conduct random weekly audits of residents with RFMS accounts to ensure responsible party or resident is receiving their RFMS statement for 4 weeks and monthly for 2 months to validate continued compliance. Any concerns addressed through the audit process will be monitored and reported Business Office Manager in summary in the facility monthly QAPI meeting. NHA will assess for trends or patterns during these meetings. 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.	

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F 568	Continued From page 7 have been legally declared incompetent to make health care/financial decisions are sent to the resident's legal representative..."	F 568		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least	F 582	F 582 **Corrective Action:** Resident #10 and Resident #27 were provided an informational notice of non-coverage on 09/13/2018. **Identification of Others:** All residents with Medicare Part A as their primary pay source have the potential to be affected. An Audit going back 30days from 10/7/2018 will be conducted to identify any potential resident that is still in the facility that converted from Medicare Part A as a primary pay source to a different paysource. An informational notice of non-coverage will be provided to any resident identified as not receiving a notice by 10/16/2018. **Systemic Change:** Education will be provided by the Divisional Director of Care Management to the RCMD, Social Services, and Business Office Manager regarding Medicare Coverage/Liability Notice by 10/16/2018. RCMD will initiate ABN notice and give to Social Services to inform and obtain signatures from the resident and/or responsible party. Business Office Manager will maintain a copy of the notice in the resident's financial file.	10/16/2018

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F 582	Continued From page 8 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of beneficiary protection notice information and staff interview, the facility failed to ensure the required notices were provided for 2 of 3 residents (#10, #27) who were reviewed. The findings were: 1. Review of beneficiary protection notice information showed resident #10 had a Medicare Part A Skilled Service Episode start date of 6/2/18. The last covered day of this Part A Service was 6/15/18. The information further showed the reason Medicare payment was ending was because it had been determined the resident no longer required skilled services. However, no Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) and no Notice of Medicare Non-coverage (NOMC) was provided to the resident or the representative.	F 582	**Ongoing Monitoring:** A weekly audit will be conducted for four weeks on all Medicare Part A residents to determine that a notice of non-coverage is given to the resident or responsible party per the regulation. After the completion of the 4 weekly audits, random audits will continue for 2 months to ensure continued compliance. Any concerns addressed through the audit process will be monitored and reported by the BOM in summary in the facility monthly QAPI meeting. DON or designee will assess for trends or patterns during these meetings. 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.	

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F 582	Continued From page 9 2. Review of the beneficiary protection notice information showed resident #27 had a Medicare Part A Skilled Service Episode start date of 2/16/18. The last covered day of this Part A Service was 4/2/18. The information further showed the reason Medicare payment was ending was because it was determined the resident no longer required skilled services. However, no Notice of Medicare Non-coverage (NOMC) was provided to the resident or the representative, and there was no explanation provided. 3. Interview on 9/13/18 at 8:58 AM with RN #5 verified the notices should have been issued.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	F609 **Corrective Action:** NHA education completed by District Director of Clinical Services on 09/11/21018 about reporting, through the Wyoming Department of Health Portal, all allegations of abuse. This incident was sent to the Wyoming Department of Health Portal on October 8, 2018. **Identification of Others:** All residents have the potential to be affected. **Systemic Change:** NHA, upon receiving an allegation, will follow policy and procedure on state reporting and verify through the Wyoming Department of Health portal that each report has been submitted. **Ongoing Monitoring:** A weekly audit for 4 weeks and then random audits monthly for two months of the Wyoming Department of Health reporting portal will be done by the DDCS to verify that all allegations were reported.	10/16/2018

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING _____ B. WING _____	C 09/13/2018

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 609	Continued From page 10 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, staff interview, and policy and procedure review, the facility failed to report 1 of 10 incidents reviewed that required reporting. This incident involved resident #16. The findings were: Review of an investigation completed by the facility showed an allegation of verbal abuse involving resident #16 was reported by a staff member to administration on 8/9/18. An investigation was conducted and completed by the administrator. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. Interview with the administrator on 9/12/18 at 3:03 PM revealed he had investigated the allegation immediately and had determined the incident to be unsubstantiated. In addition, he did not report the allegation because he made a "subjective decision and found the allegation unsubstantiated at the time it was occurring." Review of the "Abuse and Neglect Prohibition" policy last revised July 2018 showed "...1. STATE REPORTING OBLIGATIONS: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the	F 609	The results of the weekly and monthly audits, will be presented to QAPI by the NHA monthly to ensure compliance to the policy and procedure on abuse reporting. 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.	10/16/2018

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F 609	Continued From page 11 administrator, State Survey Agency..."	F 609		10/16/2018
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (I) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (II) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (III) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (I) Except as specified in paragraphs (c)(4)(II) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (II) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(I)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(I)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(I)(B) of this section;	F 623	F 623 **Corrective Action:** Resident #81 and family were provided an informational copy of the transfer/discharge notice on 9/13/2018. Residents #234 and #58 have been discharged from the facility. Any future involuntary discharge notices sent from Sheridan Manor will include the following required elements: a.The phone number, mail, and email address of the designated entity to contact related to an appeal. b.The name of the State Long-Term Care Ombudsman and the email address for contact. c. Specify Wyoming Department of Health and contact information. d. All required information for proper appeal in Wyoming. **Identification of Others:** An audit will be conducted by DON or designee of transfer/discharges in the last 30 days and informational notices will be provided to any resident identified by 10/16/2018. **Systemic Change:** At the time of discharge or transfer the licensed nurse completes the transfer /discharge notice with all of the required information and gives to the resident/family. The nurse documents that the notice was provided and a copy placed in the resident's medical record. Education will be provided by the DON or designee to all licensed nurses and social services regarding the process and regulation that residents receive a written notice of transfer and/or discharge by 10/16/2018.	

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F 623	Continued From page 12 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623	**Ongoing Monitoring:** Social Services will conduct daily audits (Monday through Friday) for 4 weeks and weekly audits for 2 months on residents that were transferred or discharged to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by Social Services, in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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F 623	Continued From page 13 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of discharge notices, the facility failed to ensure a written transfer notice was provided to 2 of 5 sample residents (#61, #234) who were hospitalized. Further, the facility failed to ensure an appropriate discharge notice was provided to 1 of 1 sample resident (#58) who was involuntarily discharged. The findings were: Regarding the content of the discharge notice: 1. Review of the discharge notice sent to the representative of resident #58 on 6/1/18 showed the resident was planned to be discharged to home by July 1, 2018 due to behaviors that affected the safety of others. The notice failed to include required elements. The elements that were missing or inaccurate included: a. The phone number, mail and email	F 623		

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F 623	Continued From page 14 address of the designated entity to contact related to an appeal. b. The name of the State Long-Term Care Ombudsman was incorrect and there was no email provided for the ombudsman. c. An unknown State Department of Public Health and Environment was listed with an address. This was described as the location where additional appeal concerns could be addressed. 2. An appeal was scheduled and prior to the appeal date a second discharge notice was issued for the resident (#58) on 8/31/18. This letter showed an update to the first notice. The resident was considered a safety risk and was being discharged from the facility with the police on that date. The notice failed to include any information related to the appeal or any further right to appeal. Further, there was no contact information provided for the State Long-Term Care Ombudsman. 3. Interview with the administrator on 9/13/18 at 1:09 PM revealed he was not aware of the missing information or these inaccuracies in the notices. Regarding transfer notices: 1. Review of a "SBAR Summary" for resident #81 dated 7/27/18 and timed 4:39 AM showed: "RN Assessment/LPN Appearance of resident-What I think is going on with the resident is: to be having difficulty breathing...Resident transferred to hospital at 0415 [4:15 AM], family notified." The following concerns were identified: a. Review of the medical record showed no evidence the facility issued a written notice of transfer to the resident or the resident's	F 623		

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F 623	Continued From page 15 representative, b. Interview with the DON on 9/13/18 at 11:53 AM revealed the facility did not issue a transfer notice, in writing, to the resident's representative. 2. Review of the medical record showed resident #234 was transferred to the hospital for an acute change of condition and returned to the facility on 8/23/18. Review of the 8/2/18 quarterly MDS assessment showed the resident had a BIMS score of 0/15 (severe cognitive impairment). Further review showed no evidence the facility issued a written notice of transfer to the resident's representative. Interview with the DON on 9/13/18 at 3:30 PM confirmed the facility had not issued a written notice of transfer to the resident's representative.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625	F 625 **Corrective Action:** Resident #81 and family were provided and informational copy of the Bed Hold notice on 9/13/2018. Resident #234 has been discharged from the facility. **Identification of Others:** An audit will be conducted by DON or designee of discharged residents in the last 30 days to identify any resident discharged without a bed hold notice. Any discharged residents identified will be provided an informational copy by 10/16/2018.	10/16/2018

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F 625	Continued From page 16 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a notice of the bed-hold policy was issued to 2 of 4 sample residents (#81, #234) with hospital transfers. The findings were: 1. Review of a "SBAR Summary" for resident #81 dated 7/27/18 and timed 4:39 AM showed: "RN Assessment/LPN Appearance of resident-What I think is going on with the resident is: to be having difficulty breathing...Resident transferred to hospital at 0416 [4:16 AM], family notified." The following concerns were identified: a. Review of the medical record showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. b. Interview with the DON on 9/13/18 at 11:53 AM revealed the facility did not issue a bed hold policy, in writing, to the resident's representative. 2. Review of the medical record showed resident #234 was transferred to the hospital for an acute change of condition and returned to the facility on 8/23/18. Review of the 8/2/18 quarterly MDS assessment showed the resident had a BIMS score of 0/15 (severe cognitive impairment).	F 625	**Systemic Change:** The nurse that discharges a resident to the hospital or therapeutic leave will send the bed hold authorization with the transfer/discharge form with the resident. A copy of the Bed Hold Authorization will go to the resident's business file. The nurse will document that the Bed Hold Authorization went with the resident. DON or designee will provide education for all licensed nurses and social services regarding the regulation and procedure for bed holds including required documentation by 10/16/2018. **Ongoing Monitoring:** Social services or designee will conduct audits on residents that were discharged or on therapeutic leave weekly for 4 weeks, and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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F 625	Continued From page 17 Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident's representative. Interview with the DON on 9/13/18 at 3:30 PM confirmed the facility had not issued a written notice of the bed-hold policy to the resident's representative. 3. Review of the policy titled "Bed Hold/Leave of Absence" last revised on 7/2016 showed "...1. Upon admission or Leave of Absence, a facility designee will prove the resident and/or responsible party written information concerning the option to exercise the Bed Hold/Leave of Absence policy...3. A copy of the Bed Hold Authorization form must be sent with the resident at the time of transfer. In case of emergency transfer, written notice to the resident and/or responsible party is provided within 24 hours of the transfer."	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessements. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review and review of the Resident Assessment (RAI) manual, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 23 (#22, #32) residents reviewed. The findings were: 1. Review of the 6/27/18 quarterly MDS assessment showed resident #22 had a cognitive status of severely impaired, required the extensive assistance of one staff member for	F 641	F 641 **Corrective Action:** MDS Section P (bed alarm) for resident #22 has been modified and MDS section I (diagnosis) for resident #32 has been modified. **Identification of Others:** A review of assessments completed within the last 30 days will be conducted to ensure bed alarms (section P) and diagnosis (section I) has been coded correctly. **Systemic Change:** The facility will ensure assessments accurately reflect the resident's status. DDCM/Designee will educate MDS Director on coding/assessing sections P (restraints) and section I (diagnosis) accurately per RAI guidelines by 10/16/2018.	10/16/2018

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F 641	Continued From page 18 transfers, had one fall with no injury since the last assessment, and bed and chair alarms were not used. The following concerns were identified: a. Observations on 9/10/18 and 9/11/18 showed the resident was in the common room of the secure unit with a chair alarm attached to his/her wheelchair or to the recliner in which s/he sat. b. Interview with RN #1 on 9/12/18 at 10:16 AM revealed the resident used both a chair and a bed alarm. c. Interview with CNA #3 on 9/12/18 at 10:25 AM revealed the resident had used a chair alarm for a "few months if not more" because s/he attempted to stand and transfer on his/her own. d. Review of the falls care plan initiated 10/20/17 showed an "electronic alarm on bed" was used to alert staff if the resident attempted to self-transfer. e. Interview with the MDS coordinator on 9/13/18 at 12:40 PM revealed the MDS assessment was completed by a staff member no longer employed by the facility and could offer no explanation of why bed and chair alarms were coded as "not used." f. According to the MDS 3.0 RAI Manual version 1.15, page 539: "Identify all alarms that were used at any time (day or night) during the 7-day look-back period, code the frequency of use...Bed alarm includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing. Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing." 2. Review of the 1/30/18 annual MDS assessment and the 7/16/18 quarterly MDS assessment for resident #32 showed the resident	F 641	**Ongoing Monitoring:** DDCM or designee will review 2-3 MDSs per week for accurate coding of sections P and I for four weeks and then monthly for 2 months. Results of Audits will be reported by the RCMD to the QAPI committee. Results of the MDS coding audit will be reported to the QAPI committee by the RCMD in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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F 641	Continued From page 19 was coded with impairment on one side of both the upper and lower extremities. Diagnoses included hypertension, hyperlipidemia, and hemiplegia; however, cerebrovascular accident (CVA) was not included. The following concerns were identified: a. Review of the history and physical printed on 1/19/17 showed "...2. History of cerebrovascular accident (CVA) status post watershed infarct with right-sided weakness ..." b. Interview with the MDS coordinator on 9/13/18 at 12:51 PM revealed the facility put in the diagnoses on any new resident MDS assessments and then they were carried over from there to the other MDS assessments. She verified the CVA should have been included.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment, (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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	F 657	F 657 **Corrective Action:** #48 (34) Care plan for resident #~~22~~ was updated to reflect appropriate use of the transfer pole on 9/12/2018. Care plan for resident #57 was updated to show footwear intervention on 9/13/2018. Care plan for resident #81 was updated to reflect use of wedge cushion on 9/12/2018. Care plan for resident #22 was updated to reflect use of bed and chair alarm on 9/12/2018. **Identification of Others:** All residents are identified as being at risk. **Systemic Change:** Education will be provided by DON or designee to all licensed nurses regarding timeliness of updating care plans with specific interventions by 10/16/2018.	10/16/2018

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F 657	Continued From page 20 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (III)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, medical record review, and review of the policy and procedure, the facility failed to ensure care plans were updated for 4 of 23 sample residents (#22, #48, #57, #81). The findings were: 1. Observation on 9/10/18 at 4:41 PM showed resident #48 had bed rails to both sides of the bed and the left side was placed against the wall. Continued observation showed a transfer pole was positioned at the lower end of the rail. Review of an "Occupational Therapy Evaluation & Plan of Treatment" dated 12/14/17 showed the transfer pole was implemented to assist the resident to sit up in bed. The following concerns were identified: a. Review of the "ADL Self-Care" care plan on 9/12/18 showed there was no evidence the care plan addressed the transfer pole. An update was added after initial review, to include the transfer pole, on 9/12/18. b. Interview with the DON on 9/13/18 at 8:19 AM revealed the appropriate use of the transfer pole should be included on the care plan. Further interview confirmed the transfer pole was not added to the care plan until 9/12/18. c. Interview with occupational therapist #1 on 9/13/18 at 8:51 AM revealed at the time the	F 657	**Ongoing Monitoring:** DON or designee will conduct random audits of 2-3 resident's care plans to ensure timely updates weekly for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by the DON or designee in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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	535026	A. BUILDING _____ B. WING _____	C 09/13/2018

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F 657	Continued From page 21 transfer pole was initiated, the resident did not have a side rail in place. Continued interview confirmed the transfer pole was to help with transfers and it was initiated on 12/14/17. 2. Interview with resident #57 on 9/10/18 at 3:14 PM revealed s/he had a sore area between his/her toes on the right foot. The resident stated a dressing was used and new shoes were in the works. The resident stated it had been about a week since the discussion of getting different shoes. Review of the weekly pressure ulcer record dated 9/2/18 showed the resident had a stage II pressure ulcer area on the right toes. The date of onset was 9/2/18 and "other interventions" were shown to be "possibly new wider shoes." Review of the 9/10/18 weekly pressure ulcer record showed the wound was improving. The following concerns were identified: a. Review of the care plan showed the issue of the pressure wound was not included on the care plan until 9/11/18, and the interventions did not include the resident's shoes/footwear. b. Interview with RN #8 on 9/13/18 at 9:47 AM revealed the resident wanted a specific brand of shoes and they had not yet been ordered. In the meantime they had loosened the laces to the resident's current shoes, and staff were aware they were not to be tied tight. The RN then verified the care plan should have been updated more timely and address the footwear intervention. 3. Observation on 9/10/18 at 2:52 PM showed resident #61 had 2 wedge cushions on his/her bed. The resident was not in the room and the cushions were not in use. The following concerns were identified: a. Review of the "Falls/Safety" care plan on	F 657		

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F 667	Continued From page 22 9/12/18 showed no evidence the care plan addressed the wedge cushions. An update was added after initial review, to include the wedge, on 9/12/18. b. Interview with the DON on 9/13/18 at 8:19 AM revealed the appropriate use of the wedge cushion should be included on the care plan. Further interview confirmed the wedge cushion was added to the care plan on 9/12/18. c. Interview with occupational therapist #1 on 9/13/18 at 8:55 AM revealed the resident was supposed to have 1 wedge cushion and was not sure why there were 2 in his/her room. Further it was revealed the wedge was being trialed in an attempt to increase the resident's comfort. 4. Review of the 6/27/18 quarterly MDS assessment showed resident #22 had a cognitive status of severely impaired, required the extensive assistance of one staff member for transfers, had one fall with no injury since the last assessment, and bed and chair alarms were not used. The following concerns were identified: a. Observations on 9/10/18 and 9/11/18 showed the resident was in the common room of the secure unit with a chair alarm attached to his/her wheelchair or to the recliner in which s/he sat. b. Review of the resident's care plan showed the use of the chair alarm was not included. c. Interview with RN #1 on 9/12/18 at 10:16 AM revealed the resident used both a chair and a bed alarm. At this time the RN reviewed the falls care plan and confirmed the use of the chair alarm was not included. d. Interview with CNA #3 on 9/12/18 at 10:25 AM revealed the resident had used a chair alarm for a "few months if not more" because s/he attempted to stand and transfer on his/her own.	F 667		

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F 657	Continued From page 23 e. Interview with the DON on 9/12/18 at 6:05 PM confirmed the care plan did not include the use of the chair alarm. 6. Review of the policy titled "Comprehensive Care Plan" last revised 11/2017 showed "...5. The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, the care plan is updated with each comprehensive and quarterly assessment in accordance with Resident Assessment Instrument (RAI) requirements..."	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to adequately assess 1 of 3 sample residents (#28) with a change in condition. The findings were: 1. Review of the significant change MDS assessment dated 9/7/18 for resident #28 showed the BIMS score was 13/15 (cognitively intact) and the resident required extensive assistance for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene.	F 684	F 684 **Corrective Action:** Resident #28 received wound care and assessment to gluteal fold wounds on 9/10/2018. CNA #7 was educated by DON on the procedure for notifying the nurse immediately when a new wound is identified or wound treatment is needed on 09/13/2018. **Identification of Others:** All residents have the potential to be affected. **Systemic Change:** DON or designee will educate all CNAs on reporting skin changes to the nurse immediately by 10/16/2018.	10/16/2018

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SHERIDAN MANOR	1661 BIG HORN AVE SHERIDAN, WY 82801

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F 684	Continued From page 24 Further review showed the resident was at risk for developing pressure ulcer/injuries and had no other skin problems. The following concerns were identified: a. Observation on 9/10/18 at 3:32 PM showed the resident had a wound on his/her left lower leg above a Coban dressing. In addition, there were 2 wounds on the resident's right gluteal fold (buttock crease). One of these areas appeared to be blistered and the other was a dime-sized open red wound. Interview with CNA #7 at that time revealed the resident scratched and opened the skin. As the staff rolled the resident from side to side to dress him/her, blood was visible on the incontinence pad. b. Continued observation at 4:21 PM showed RN #6 treated the wound on the resident's left lower leg with wound cleanser and dressed the wound with a padded dressing. She then placed compression socks on the resident. The RN was not made aware of the wounds on the right buttock crease and therefore did not provide any assessment or treatment. c. Interview with the DON on 9/12/18 at 1:47 PM revealed the facility's expectation was for the CNA to report the wound to the nurse immediately, and the nurse was to respond and assess as soon as possible. The wound should be documented, and the physician and family notified. d. Review of a late entry progress note dated 9/12/18 at 6:06 PM with an effective date of 9/10/18 at 5:09 PM showed "Cleanse with wound cleanser and allow to dry. Apply smaller foam dressing to distal open wound and medium size foam dressing to proximal open wound. [O]ne time a day every other day for Open Wounds to Right Gluteal Fold Order changed by the nurse manager and dressing changed by her today."	F 684	**Ongoing Monitoring:** DON or designee will conduct random audits of 5 resident's skin condition through observation for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by DON or designee in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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F 684	Continued From page 25 e. Interview with CNA #8 on 9/13/18 at 8:45 AM revealed if a resident had a new wound, the procedure was to take the resident to their room and report it immediately to the nurse to assess.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690	F 690 **Corrective Action:** CNA #6 was educated on proper perineal care of the male patient on 9/13/2018. **Identification of Others:** All incontinent residents are identified as having potential to be affected. **Systemic Change:** Education will be provided by DON or designee to all CNAs on proper perineal care by 10/16/2018. **Ongoing Monitoring:** DON or designee will conduct random audits of incontinent residents for proper perineal care weekly for 4 weeks and monthly for 3 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by DON or designee in summary in the facility monthly QAPI meeting. IDT will assess for trends or patterns during these meetings. 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.	10/16/2018

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F 690	Continued From page 26 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure appropriate incontinence care was provided for 1 of 9 sample residents (#81) reviewed for incontinence. The findings were: Review of the significant change MDS assessment dated 8/8/18 showed resident #81 had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, encephalopathy, and muscle wasting. Further review showed the resident required extensive assistance of two or more people for transfers and toilet use. The resident required extensive assistance of 1 person for personal hygiene. The following concerns were identified: a. Observation on 9/12/18 at 9:31 AM showed unit manager #1 assisted the resident into his/her room and obtained the mechanical lift. Continued observation showed CNA #8 assisted the unit manager to transfer the resident using the mechanical lift. When the staff members removed the resident's pants, feces fell on the commode and the floor. The resident was assisted onto the commode and the CNA pulled the resident's pants down further to remove the resident's brief. While the resident was seated on the commode, s/he urinated and the urine rolled down his/her legs onto the floor. The CNA wiped the resident's right leg with a wipe multiple times without changing the area of the wipe. The CNA then used the same wipe to wipe the resident's genitalia. The CNA wiped the resident's perineal	F 690		

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F 690	Continued From page 27 area and in between the resident's legs, which resulted in the wipe being visibly soiled with feces. The CNA then used the visibly soiled wipe to wipe the resident's genitalia. The CNA and nurse applied a clean brief to the resident's legs and placed the sling behind the resident while s/he sat on the commode. After lifting the resident off the commode with the mechanical lift, the CNA wiped the resident's buttocks and rectal area from back to front and then front to back with the same wipe, discarded the wipe, and performed the cleaning practice the same way with another wipe. The CNA obtained more wipes and again wiped from the resident's rectal area towards the genitalia. b. Review of the resident's "Infection" care plan last revised on 7/31/18 showed the resident had a history of urinary tract infection. c. Review of the resident's "Elimination" care plan last revised on 2/16/17 showed the resident had bowel and bladder incontinence, and cognitive impairment. Further, the resident required extensive assistance of 1 for perineal care. d. Interview with the DON on 9/13/18 at 8:12 AM revealed perineal care should be provided from front to back, staff should not use the same area of a wipe more than once, and a visibly soiled wipe should not be used to clean a resident's genitalia. e. Review of the procedure titled "Perineal care of the male patient" last revised on 11/17/17 showed "Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and after urination and bowel movements in cases of incontinence. The procedure promotes cleanliness and prevents infection...Using disposable cloths...Clean the penis with the cloth,	F 690		

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F 690	Continued From page 28 beginning at the tip and working in a circular motion from the center to the periphery to avoid introducing microorganisms into the urethra. Use a clean section of cloth for each stroke to prevent the spread of contaminated secretions or discharge...Using downward strokes toward the scrotum, clean the rest of the penis..."	F 690	F 729 **Corrective Action:** CNA #1 verification of abuse registry was received on 9/12/2018. CNA #2 verification of abuse registry was received on 9/12/2018.	
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (I) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (II)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the	F 729	**Identification of Others:** All CNAs currently employed at facility will be audited to verify abuse registry compliance by 09/28/2018. **Systemic Change:** DON or designee will verify prior to employment that all CNAs are registered with the State Nurse Aid Registry and are clear of abuse. HR Area Manager will educate DON, SDC, and Unit Manager on the use of the CAN Abuse registry and procedure to ensure all employees are compliant prior to employment by 10/16/2018. **Ongoing Monitoring:** DON or designee will conduct audits of all newly employed CNAs for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by the DON or designee in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns. 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.	10/16/2018

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F 729	Continued From page 29 individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on review of employee files, policies and procedure review and staff interview, the facility failed to ensure the State nurse aide abuse registry was checked prior to resident contact for 2 of 3 sample CNAs (#1, #2) reviewed. The findings were: 1. Review of the employee files for CNAs #1 and #2 revealed verification from the State nurse aide registry had been received for the 2 CNAs and did not have abuse/neglect findings. However, this review also revealed the facility did not receive the verifications until after the CNAs had resident contact. The following concerns were identified. a. CNA #1 was hired on 7/6/18 and verification was received on 9/12/18 (68 days). b. CNA #2 was hired on 7/6/18 and verification was received on 9/12/18 (68 days). 2. Interview with the administrator on 9/12/18 at 11 AM verified evidence the CNA abuse registry had been checked was not obtained until 9/12/18. Further, the facility currently did not have a human resource position and the responsibilities for this position were shared between several staff members. 3. Review of the policy and procedure titled "Abuse and Neglect Prohibition" revised July 2018, showed "The facility does not hire or otherwise engage individuals who have findings	F 729		

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F 729	Continued From page 30 on the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property."	F 729		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and medical record review, the facility failed to ensure behavioral health services were provided for 1 of 6 sample residents (#44) with these service needs. The findings were: Interview with resident #44 on 9/10/18 at 3:50 PM revealed s/he "gets down" about his/her condition and not being able to live in his/her own home. Further, the resident wanted to go to a different facility and there was difficulty with placement. The resident also mentioned s/he had talked with a counselor in the past and thought it would be helpful to resume. The following concerns were identified: s. Review of the care plan showed the resident had a diagnosis of bi-polar disorder, and an intervention dated 2/18/16 for behavioral help	F 740	F 740 **Corrective Action:** Social Services Director met with a new counseling group on 9/16/2018 that will potentially be able to provide services to resident #44 by 10/16/2018. Frequent social services visits from facility staff have been established for resident #44 while services are set up. **Identification of Others:** All residents with a psychiatric diagnosis will be reviewed and interviewed by social services or designee by 10/16/2018 to determine if further mental health services are needed or desired. **Systemic Changes:** Social Service will internally provide services for identified residents until further counseling services are available in the community.	10/16/2018

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	535026	A. BUILDING _____ B. WING _____	C 09/13/2018

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 740	Continued From page 31 in group and individual therapy. b. Review of the behavioral therapy service notes showed there had been no notes since 10/16/17. c. Interview with the social service director on 9/13/18 at 1:38 PM revealed she was unable to find any documentation as to why the services were stopped. The director stated a new counseling group was being contacted.	F 740	**Ongoing Monitoring:** DON or designee will conduct weekly audits of 2-3 residents with psychiatric diagnosis to determine if behavioral health needs are met for 4 weeks and then random monthly audits for 2 months to ensure continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by Social Services Director in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (I) Anti-psychotic; (II) Anti-depressant; (III) Anti-anxiety; and (IV) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	F 758 **Corrective Action:** PRN Ativan order for resident #27 was reviewed with physician. It was discontinued related to non-use on 9/27/2018. Behavior monitoring for resident #27 for anxiety and depression has been implemented on 10/7/2018 to determine effectiveness of medication. **Identification of Others:** An audit of all residents with PRN orders for anti-anxiety medications will be conducted by 10/16/2018 to determine effectiveness, need for continued use, and/or risk vs. benefit statement from physician.	10/16/2018

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F 758	Continued From page 32 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure the drug regimen was free of unnecessary medications for 1 of 5 sample residents (#27) reviewed for appropriate medication use. The findings were: Review of the quarterly MDS assessment dated 7/2/18 showed resident #27 had diagnoses which included anxiety disorder and depression, had a mood score of 2 (minimal), and a brief interview for mental status (BIMS) score of 15. Further review showed the resident had no behaviors exhibited. The following concerns were identified: a. Review of the physician orders showed Ativan (anti-anxiety medication) 0.5 mg (milligrams) 1 tablet by mouth at bedtime was	F 758	**Systemic Changes:** DON provided education for the attending physician on 9/13/2018 regarding the regulation that PRN anti-anxiety medication should not be used longer than 14 days. If it is used longer than 14 days a risk vs. benefit statement will be provided by the physician to the resident or responsible party. DON or designee will provide education to all licensed nurses that PRN anti-anxiety orders should not be used longer than 14 days. If these orders exceed 14 days, notification to physician is necessary. Education will be completed by 10/16/2018. The IDT team will review all new psychotropic medication orders to implement behavior monitoring and effectiveness of medication. **Ongoing Monitoring:** DON or designee will conduct random audits of 5 residents who are receiving psychotropic medication for behavior monitoring and evaluation of effectiveness for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by DON or designee in summary in the facility monthly QAPI meeting for 3 months. IDT will assess for trends or patterns during these meetings. 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.	

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F 758	Continued From page 33 ordered on 7/26/18 and Ativan 0.5 mg by mouth once daily as needed (PRN) was ordered on 7/27/18 for anxiety. Further, Cymbalta (anti-depressant medication) 60 mg by mouth every day was ordered on 2/16/18 for depression. The following concerns were identified: b. Review of the medical record showed no evidence of identified behaviors or monitoring related to the use of these medications. c. Review of a "Note to Attending Physician/Prescriber" dated 6/20/18 showed the pharmacist requested a "risk vs benefit" or discontinuation of the PRN Ativan and the physician responded on 7/5/18 by checking the "disagree" box and wrote "Benefit out way risk." There was no rationale for continued use provided. d. Review of a "Note to Attending Physician/Prescriber" dated 7/16/18 showed the pharmacist requested a "risk vs benefit" or discontinuation of the PRN Ativan and the physician responded on 8/2/18 by checking the "disagree" box. There was no rationale for continued use provided. e. Interview with the DON on 9/13/18 at 11:19 AM revealed behavior monitoring was not completed for the resident related to anxiety or depression. In addition, she verified the physician had not provide a rationale for the extended use of the PRN Ativan, and the facility could not evaluate the effectiveness of the medications. f. Review of the policy titled "Psychotropic Management" last revised on 11/2017 showed "...A PRN (as needed) order for psychotropic medications should not be written unless such medication is necessary to treat a diagnosed, specific condition that is documented in the medical record. PRN orders for psychotropic medications are limited to 14 days, except as	F 758		

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F 758	Continued From page 34 provided by Federal regulation, and cannot be renewed unless the Attending Physician or prescribing Licensed Practitioner evaluates the resident for the appropriateness of that medication. If the Attending Physician or prescribing Licensed Practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order...Unnecessary Drugs and Psychotropic Drugs...Each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being...Practice Guidelines...6. The licensed nurse will institute the appropriate behavior monitoring for associated with medication category via the Behavior Care Record and the Side Effect Care Record..."	F 758		
F 803 SS=E	Menus Meet Resident Nds/Prep In Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident	F 803	F 803 **Corrective Action:** Affected residents were offered additional food at meal time on 9/12/2018. Dietary Manager purchased correct size scoops that day and ordered more for replacements 9/13/2018. Education was completed with dietary staff on 09/12/2018 by Dietary Manager about proper scoop and portion sizes. **Identification of Others:** All residents have the potential to be affected. **Systemic Changes:** Dietary manger or designee will assure that all new staff, when hired, are educated on correct portions and scoop sizes. Dietary manager or designee will ensure that ample supply of proper scoops are available to staff.	10/16/2018

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F 803	Continued From page 35 groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the planned menu, the facility failed to ensure the menu was followed for 3 of 5 residents (#10, #16, #42) with orders for mechanical texture. The findings were: Review of the noon menu for 9/12/18 showed 4 ounces of meatballs including sauce, and then 2 ounces of marinara sauce were planned to be served for the spaghetti meal. Observation on 9/12/18 at 11:16 AM showed the cook had prepared the meatballs separate from the sauce. When interviewed at 11:30 AM, cook #1 stated they would serve 3 ounces of meatballs and 2 ounces of the sauce. This was for the regular texture and the mechanical texture. The following concerns were identified: a. Observation in the memory care dining room showed cook/server #2 served resident #10 a mechanical diet. The portion of mechanically ground meatballs served was a 2 ounce measured scoop. In addition, residents #16 and #42 had orders for mechanical diets and double portions. Each of these residents were served 4 ounces of mechanically ground meatballs. A double portion would have been 6 ounces based	F 803	**Ongoing Monitoring:** Dietary Manager or designee will do audit of utensils being used for proper portion sizing weekly x 4 and then randomly for 2 months. All audits will be presented by Dietary Manager to QAPI monthly for 3 months to ensure compliance. Dietary manager or designee will observe meals to ensure that proper scoops are being used and report findings monthly to QAPI to evaluate compliance 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.	

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F 803	Continued From page 36 on the planned menu. b. Interview with cook/server #2 on 9/12/18 at 12:16 PM revealed she was not aware of the actual portion size to use for the mechanical texture meatballs. c. Interview with the dietary manager on 9/12/18 at 12:16 PM, who was assisting with the service, revealed there was no 3 ounce scoop, so the #16 (2 ounces) scoop was being used and would require 1 and 1/2 scoops to be served. He then verified the information was not effectively communicated for the servers and these residents had been underserved.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and review of recipes, the facility failed to ensure the food was palatable in taste during 1 of 1 food service observation. The findings were: Interview with residents revealed the quality of the food was lacking. In an interview on 9/11/18 at 1:44 PM, a resident stated, "The food isn't really good..." On 9/10/18 at 3:04 PM another resident stated, s/he didn't like the food, saying, "it's real cheap and the cook doesn't know how to cook	F 804	F 804 **Corrective Action:** Cooks were educated by Dietary Manager on the importance of following recipes on 09/12/2018. **Identification of Others:** All residents who have meals served by dietary staff have the potential to be affected.	10/16/2018

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F 804	Continued From page 37 much." On 9/10/18 at 3:30 PM, a resident said the quality of the food, "is fair, they don't go out of their way to be good to us." Observation of a test tray with the dietary manager on 9/12/18 at 12:35 PM revealed the marinara sauce was bland with no seasoning. The sauce appeared to be canned tomato sauce with no visible spices. Interview with the dietary manager at that time revealed he would check with the cook to see how it was made. Interview with the dietary manager and the assistant dietary manager on 9/12/18 at 1:10 PM verified some of the cooks were new and more training was required to ensure the quality of the food was consistently good. The dietary manager stated through his discussion with the cook, he found the recipe for the marinara sauce that day was not followed. He further confirmed the ingredients were available. Review of the marinara sauce recipe provided by the dietary manager showed in addition to the tomato sauce, fresh onion, garlic powder, sugar, and dried basil leaf were to be added.	F 804	**Systemic Changes:** Dietary manager or designee will randomly audit meals by taste test and determine if food is palatable and tasteful. Audits will be completed weekly on alternating shifts for 3 months. Dietary manager or designee will randomly observe cooks to make sure that menus are followed and prepared according to provided recipes. Audits will be weekly on alternation shifts for 3 months. NHA or designee will randomly taste food for palatability and taste for 3 months. **Ongoing Monitoring:** Audits will be presented monthly to QAPI for compliance evaluation by Dietary Manager. 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. 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.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	F 880 **Corrective Action:** A: Recliner that resident #25 sat in after being incontinent was removed from the public area and cleaned/disinfected on 9/11/2018. B: RN #6 was educated on proper hand hygiene during dressing changes on 09/11/2018. C: CNA #6 was educated on proper perineal care of the male patient on 9/13/2018 by Unit Manager.	10/16/2018

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F 880	Continued From page 38 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F 880	**Identification of Others:** A: All public seating surfaces on Memory Care Unit have the potential to be soiled. B: All residents requiring dressing changes have the potential to be affected. C. All male incontinent residents requiring perineal care by staff members have the potential to be affected. **Systemic Changes:** A: DON or designee will educate on soiled public seating surfaces for all direct care staff and housekeeping staff by 10/16/2018. B: DON or designee will educate all licensed nurses on proper hand hygiene during dressing changes by 10/16/2018. C: DON or designee will educate all CNAs on proper perineal care for male residents by 10/16/2018.	

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F 880	Continued From page 39 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedures, staff interview, and review of professional standards, the facility failed to ensure adequate infection control practices during 3 random observations (involving residents #22, #25, #47, #91). The findings were: 1. Observation on 9/11/18 at 8:31 AM showed resident #25 was asleep in a recliner in the common room of the memory care unit. The front of the resident's pants appeared to be wet and discolored. Housekeeper #1 was the only staff member in the area at that time. At 8:35 AM activity aide/CNA #4 arrived with the activity cart. At 8:42 AM the resident stood up and the housekeeper alerted the CNA to the resident's incontinence. At that time the resident's pants were noted to be soiled from front to back. The CNA took the resident to his/her room to provide incontinence care. However, the CNA and housekeeper failed to clean the recliner the	F 880	**Ongoing Monitoring:** A: DON or designee will conduct random audits of public seating surfaces in the Memory Care Unit for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. B. DON or designee will conduct random audits of proper hand hygiene during dressing changes for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. C: DON or designee will conduct random audits for proper perineal care of the male patient for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by DON or designee in summary in the facility monthly QAPI meeting. IDT will assess for trends or patterns during these meetings. 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	

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SHERIDAN MANOR	1551 BIG HORN AVE SHERIDAN, WY 82801

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F 880	Continued From page 40 resident had been sitting in. At 8:48 AM resident #22 was brought to the common room and was transferred into the recliner resident #25 had vacated. Interview on 9/11/18 at 4:48 PM with the DON and infection control practitioner revealed their expectation was for staff to clean a recliner that was soiled prior to placing a resident in the chair. 2. Observation of wound care for resident #47 on 9/11/18 at 9:21 AM showed the resident had dressings to bilateral lower extremities. On 9/11/18 at 10:32 AM, RN #6 entered the resident's room to perform wound care. The RN donned gloves; however, she failed to perform hand hygiene. The RN removed dressings on both lower extremities, cleaned the wounds, and measured the wounds. Continued observation showed the RN did not change her gloves, between the dirty dressing removal, preparing supplies, and the application of the clean dressing. The following concerns were identified: a. Interview with the DON and infection control preventionist on 9/11/18 at 4:48 PM revealed the facility's expectation was for staff to follow the facility policy which was to perform hand hygiene before dressing care and during wound care. b. Review of the "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendoff (2016), sixth edition showed: "Implementation for Applying a Gauze Dressing... 1. ...Standard Protocol... 3. Apply clean gloves... 4. ...remove tape, bandage... 6. ... Dispose of gloves and soiled dressings. Perform hand hygiene. 7. Create a sterile field with a sterile dressing or individually wrapped sterile supplies... 8. Apply clean gloved... 10. Inspect wound... Use measuring guide or ruler to measure wound	F 880		

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F 880	Continued From page 41 size... 11. Apply antiseptic ointment (if ordered)... Dispose of gloves. Perform hand hygiene. 12. Apply dressing... 13. Secure dressing... 14. Label dressing... dispose of used supplies and equipment... 15. Remove and dispose of gloves ...Perform hand hygiene." c. Review of the policy and procedure "Sava Wound assessment" revised August 17, 2018 showed ..."Gather the necessary equipment. Perform hand hygiene... Protect patient's dignity by exposing on the wound and keeping other body parts well covered. Perform hand hygiene, put on gloves... Remove the old dressing, inspect and assess the wound...Remove and discard your gloves, perform hand hygiene. Open and prepare the supplies... Perform hand hygiene, put on a new pair of gloves... Apply the appropriate wound care treatments and dressing... Dispose of used supplies... Remove and discard gloves... Perform hand hygiene." 3. Review of the significant change MDS assessment dated 8/6/18 showed resident #81 had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, encephalopathy, and muscle wasting. Further review showed the resident required extensive assistance of two or more people for transfers and toilet use. The resident required extensive assistance of 1 person for personal hygiene. The following concerns were identified: a. Observation on 9/12/18 at 9:31 AM showed the resident was requesting staff to take him/her to the bathroom. When the staff members removed the resident's pants, feces fell on the commode and the resident's floor. The resident was assisted onto the commode and CNA #6 pulled the resident's pants down further to remove the resident's brief. While the resident	F 880		

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SHERIDAN MANOR	1951 BIG HORN AVE SHERIDAN, WY 82801

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F 880	Continued From page 42 was seated on the commode, s/he urinated and the urine rolled down his/her legs onto the floor. The CNA wiped the resident's right leg with a wipe multiple times without changing the area of the wipe. The CNA used the same wipe to wipe the resident's genitalia. The CNA wiped the resident's perineal area and in between the resident's legs, which resulted in the wipe being visibly soiled with feces. The CNA then used the visibly soiled wipe to wipe the resident's genitalia. The CNA and nurse applied a clean brief to the resident's legs and placed the sling behind the resident while s/he sat on the commode. After lifting the resident off the commode with the mechanical lift, the CNA wiped the resident's buttocks and rectal area from back to front and then front to back with the same wipe, discarded the wipe, and performed the cleaning practice the same way with another wipe. The CNA obtained more wipes and again wiped the resident's rectal area towards the genitalia. The CNA reached into the package of clean wipes and handled the clean wipes with gloved hands, after providing the perineal care, then handed the contaminated wipes package to the resident to hold while the CNA continued to provide perineal care. The resident held the wipes package against his/her shirt for the remainder of perineal care. The wipes package was discarded; however, the nurse and the CNA did not change the resident's shirt. b. Review of the resident's "Infection" care plan last revised on 7/31/18 showed the resident had a history of urinary tract infection. c. Interview with the DON on 9/13/18 at 8:12 AM revealed perineal care should be provided from front to back, staff should not use the same area of a wipe more than once, and a visibly soiled wipe should not be used to clean a	F 880		

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F 880	Continued From page 43 resident's genitalia. e. Review of the procedure titled "Perineal care of the male patient" last revised on 11/17/17 showed "Perineal care, which includes care of the external genitalia and the anal area, should be performed during the daily bath and after urination and bowel movements in cases of incontinence. The procedure promotes cleanliness and prevents infection...Using disposable cloths...Clean the penis with the cloth, beginning at the tip and working in a circular motion from the center to the periphery to avoid introducing microorganisms into the urethra. Use a clean section of cloth for each stroke to prevent the spread of contaminated secretions or discharge...Using downward strokes toward the scrotum, clean the rest of the penis..."	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of policy and procedures, the facility failed to ensure an antibiotic stewardship program was implemented to monitor antibiotic use for 1 of 4 residents (#66) reviewed for infections. The findings were:	F 881	F 881 Corrective Action: A Risk vs. Benefit statement for prophylactic use of antibiotic for resident #66 was provided by physician on 9/12/2018. Education was provided by DON to attending physician on antibiotic stewardship program requirements for long term use of antibiotics on 9/16/2018. Identification of others: An audit was conducted on 10/1/2018 on all antibiotic orders to determine if other residents were using prophylactic antibiotics. Two additional residents were identified as having orders for prophylactic antibiotics. Requests given to primary care physician to review and discontinue or provide risk vs. benefit statement by physician before 10/16/2018.	10/16/2018

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F 881	Continued From page 44 1. Review of the 8/8/18 quarterly MDS assessment showed resident #88 had diagnoses which included neurogenic bladder, obstructive uropathy, dementia, and hemiplegia or hemiparesis. Further review showed the resident had a urinary catheter and used an antibiotic for each day of the 7-day look-back period. In addition, the resident had 2 or more falls with no injury and 1 fall with an injury since the last MDS quarterly assessment date of 7/18/18. The following concerns were identified: a. Review of a physician communication form dated 12/29/17 written by a RN showed "[the resident] has been experiencing chronic UTIs (urinary tract infections) and they are often associated with a fall (fall 12/28/17) [the resident] does have a long-term foley catheter in place as well. Should a long-term antibiotic be considered at this time?" b. Review of a physician order dated 1/2/18 showed Macrobid (an antibiotic) capsule 100 mg (milligrams) was ordered one time a day for UTI prophylaxis. There was no end date indicated. 2. Interview with the DON and infection control practitioner on 9/11/18 at 4:48 PM revealed there was no documentation to show the physician or nursing staff were educated on the risks of using a prophylactic antibiotic. Further a risk/benefit statement was not available. On 9/13/18 at 1:35 PM the DON confirmed there was no information available related to the education of the physician about prophylactic antibiotics. 3. Review of the Antibiotic Stewardship policy last revised 2/2018 showed the responsibilities of the Director of Nursing: "...Educates nursing staff about the importance of antibiotic stewardship and explains policies in place to improve	F 881	**Systemic Changes:** DON or designee will provide education to all licensed nurses regarding antibiotic stewardship program and antibiotic use protocols by 10/1262018. If an antibiotic order is received from the physician without a stop date, the licensed nurse will notify the physician to request stop date. If an antibiotic order is received for prophylactic use, DON or designee will ensure physician provides a risk vs. benefit statement for continued use. **Ongoing Monitoring:** DON or designee will conduct an audit of all newly prescribed antibiotics weekly for 4 weeks and then random audits monthly for 2 months to validate continued compliance. Corrective action will be taken as necessary for any identified concerns. Any concerns addressed through the audit process will be monitored and reported by DON or designee in summary in the facility monthly QAPI meeting. IDT will assess for trends or patterns during these meetings. 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.	

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F 881	Continued From page 45 antibiotic use..." The responsibilities of the Infection Preventionist included "...Participates in educational activities related to antibiotic stewardship for facility staff..." In addition the policy stated "Physician Responsibility when Considering Prescribing antibiotic Therapy...Avoid long-term antibiotic prophylaxis for preventing infections such as urinary tract infections."	F 881		
F 923 SS=D	Ventilation CFR(s): 483.90(i)(2) §483.90(i)(2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure adequate ventilation was maintained in 1 of 4 resident care areas (500 unit). The findings were: 1. Observation on 9/10/18 at 3:19 PM showed a urine smell was present outside of room 503. 2. Observation on 9/10/18 at 4:40 PM showed a fecal smell was present near room 502. 3. Observation on 9/11/18 at 11 AM showed an unidentified CNA stated the 500 unit "stunk" and the CNA and a housekeeper sprayed air freshener in the hall to "get rid of the smell." 4. Observation of room 508 on 9/13/18 at 11:05 AM showed bathroom ventilation was not working. 5. Observation of room 504 on 9/13/18 at 11:06 AM showed bathroom ventilation was not	F 923	F 923 **Corrective Action:** Maintenance Director and Maintenance Assistant corrected bathroom ventilation fans working on 500 hall 10/16/2018. **Identification of Others:** All resident rooms with bathroom ventilation fans have the potential to be affected. **Systemic Changes:** Audit will be completed by the Maintenance Director or designee on the 7 exhausters bi-weekly to ensure ventilation is operative for 3 months. **Ongoing Monitoring:** All audits will be presented to QAPI monthly by Maintenance Director or designee to evaluate compliance. 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.	10/16/2018

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F 923	Continued From page 46 working. 6. Observation of room 503 on 9/13/18 at 11:09 AM showed bathroom ventilation was not working. 7. Observation of room 509 on 9/13/18 at 11:10 AM showed bathroom ventilation was not working. 8. Interview with the maintenance director on 9/13/18 at 11:25 AM revealed she was not aware the ventilation did not work on the 500 hall. 9. Observation on 9/13/18 at 11:29 AM showed the maintenance director checked the bathroom vent in room 503. Interview at that time confirmed the ventilation system was not working.	F 923		

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