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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 8/27/19. The survey was prompted by complaint intakes WY00002926 and WY00002927.	F 000	**F 600** Corrective Action: Resident #1 was placed on 1:1 supervision. ID of others:	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on review of facility incident reports and documentation, staff and resident interviews, observations, medical record review and review of personnel files and policies and procedures, the facility failed to ensure residents were free from abuse for 1 of 3 residents (#2) reviewed. The findings were: Review of the progress noted dated 8/22/19 and timed at 4:30 PM showed resident #2 "... was in the dining room when [resident #1] became physically aggressive with [him/her] striking [him/her] in the face with a coffee cup several	F 600	Review of the 24hr report and current resident's most recent MDS assessments to determine if any other residents are at risk for similar behavioral outbursts. Any residents identified as having at risk behaviors have been reviewed by Interdisciplinary Team and updated current care plans to minimize risk of outbursts. Random resident interviews were performed to identify if any similar incidents had occurred or if any residents were fearful. Systemic Changes: DDCS educated Interdisciplinary Team on 9/23/19 on abuse, abuse prevention, and recognizing residents with at risk behaviors. Then DON/designee educated all facility employees on definition of abuse, abuse prevention, and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heidi Heuman, NHA | TITLE: NHA | (X6) DATE: 9/20/19

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.

RECEIVED
SEP 27 2019
Healthcare Licensing and Surveys
09/27/2019 FRI 15:59 FAX

9/27/19 at 3:25 PM - I spoke with the administrator. Plan accepted.

ETO/900

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F 600	Continued From page 1 times causing facial injuries to forehead, nose, upper lip and chin - areas cleansed with NS [normal saline] and resident sent to the ER [emergency room] for evaluation and treatment via [ambulance service]." Interview on 8/27/19 at 11:20 AM with resident #2 revealed on 8/22/19, resident #1 was wandering around holding his/her pants up with one hand. Resident #2 was at the coffee pot. Resident #1 had let his/her pants fall to the floor. Resident #2 told him/her to "Pull your damn pants up", and resident #1 hit resident #2 four or five times in the face with a coffee cup. Resident #2 stated, "I got a scrape above my left eye and a little cut by my nose. They sent me to the hospital, but it was nothing." Observation on 08/27/19 11:30 AM showed resident #2 had a 1.5 to 2 cm abrasion in the eyebrow above the left eye, and a small 0.5 cm laceration beside the nose on the right side. Neither laceration had sutures, and both sites were open to air. Telephone interview with CNA #1 on 08/27/19 at 11:43 AM revealed on 8/22/19 the CNA was attending to another resident when he heard shouting from across the dining room. He saw resident # 1 strike resident #2 several times with a coffee cup. The CNA interceded between the residents and easily redirected resident #1. Interview with the director of nursing on 8/27/19 at 10 AM revealed the facility sent resident #1 "...to the jail and did not plan on ever taking [him/her] back."	F 600	behavior management including recognizing those resident with at risk behaviors. Education occurred on/or before date of compliance. Monitoring: 24 hour report will be reviewed daily Monday – Friday to identify any residents with new occurrences of at risk behaviors. Residents identified with new at risk behaviors will have care plans reviewed and updated to ensure that appropriate interventions are in place. NHA/designee will track and trend results of the audits completed and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	
F 622	Transfer and Discharge Requirements	F 622		

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F 622 SS=D	Continued From page 2 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622	**F 622** Corrective Action: Resident #1 was re-admitted to the facility on 8/23/19. ID of others: Review of Immediate discharges during the previous 30 days to ensure appropriate guidelines were followed. Systemic Change: DDCS provided education to Interdisciplinary Team on 9/23/19 regarding appropriate discharge guidelines. Monitoring: Facility potential immediate discharges will be reviewed by NHA/DON prior to discharge to ensure they are compliant with state and federal regulation requirements and appropriate documentation is in the resident record.	

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	535028	A. BUILDING _____ B. WING _____	C 08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1681 BIG HORN AVE SHERIDAN, WY 82801

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F 622	Continued From page 3 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622	NHA/designee will track and trend results of the audits completed and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 622	Continued From page 4 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, law enforcement personnel interview, review of the facility's incident log and incident investigations, review of discharge documents, and observation, the facility failed to ensure a decision to discharge a resident from the facility was not based on the resident's condition at the time of emergency transfer for 1 of 3 residents (#1) reviewed. The findings were: Review of the quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/25/19 for resident #1 showed the resident admitted to the facility on 11/5/16, and had diagnoses that included traumatic hemorrhage of left cerebrum with loss of consciousness of unspecified duration, bipolar disorder, seizure disorder or epilepsy, and anxiety disorder. The assessment also showed the resident had a brief interview for mental status (BIMS) score of 12, indicating moderate cognitive impairment. The resident was not coded as having physical, verbal, or other behaviors. The resident was coded as having wandered on 4 to 6 days during the look-back period. Review of the quarterly MDS assessment with an ARD of 5/13/19 showed the resident had a BIMS score of 5, indicating severe cognitive impairment. Review of the resident's care plan, initiated 6/14/17,	F 622		

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F 622	Continued From page 5 showed "Resident will remain at [the facility] until alternative placement can be found. Review of the facility's incident report log showed the resident had an altercation with another resident on 8/22/19 which was listed as an "aggression initiated incident". Review of the behavior note dated 8/22/19 and timed 4:14 PM showed "4:15 PM, yelling in the dining room. This writer went to the dining room where [CNA #1] was trying to move [resident #1] away from [resident #2]. [Resident #1's] pants were down to [his/her] ankles. [Resident #2] stated I had told [resident #1] to "Pull [his/her] damn pants up." [Resident #1] then proceeded to hit [resident #2] in the face with [his/her] coffee cup an estimated 4 or 5 times drawing blood. When [resident #1] was finished [s/he] poured self a cup of coffee and walked away as if nothing had happened." Review of the facility's investigation showed resident #1 was "discharged from the facility in the custody of the police department and provided a notice of immediate discharge." The following concerns were identified: Review of the nursing note dated 8/22/19 and timed 9:14 PM showed "Immediate discharge notice was provided to the police department to give to [resident #1]." Review of a letter from the facility dated 8/22/19 and signed by the facility administrator, and addressed to resident #1 at the county jail showed "This letter is to notify you of [the facility's] decision to discharge you, immediately and involuntarily, due to your continued non-compliance with your plan of care and because your behavior is such that it places you and other residents at serious risk of harm." The letter further showed the county jail as the	F 622		

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F 622	Continued From page 6 location to which the resident was being discharged. Review of the MDS discharge tracking record with an ARD of 8/22/19 showed the resident had been discharged from the facility with return not anticipated. Review of the progress note dated 8/22/19 and timed 7:38 AM showed "Due to [resident #1's] discharge from facility yesterday, the significant change assessment which was scheduled for 8/28 was changed to a discharge tracking record and will not be completed." Interview with the director of nursing on 8/27/19 at 10 AM revealed the facility sent the resident "...to the jail and did not plan on ever taking [him/her] back." Interview with the facility administrator on 8/27/19 at 2 PM confirmed that the letter of involuntary discharge was "sent to the jail, and with no intention of the resident ever coming back to [the facility]." Interview with law enforcement officer #1 on 8/27/19 at 3:15 PM revealed he was concerned because the letter of discharge was sent to the jail and addressed as if the jail were the resident's permanent address, and the resident was "unable to know where [s/he] was or why [s/he] was in jail". The officer further noted the resident had not been aggressive or violent during his/her time at the jail, and law enforcement subsequently took the resident from the jail to the hospital because the jail was unable to care for the resident due to his/her physical and mental needs and the lack of medical staff at the jail to handle and dispense the resident's required medications.	F 622		

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F 622	Continued From page 7 Further review of the facility's incident investigation showed the facility administrator and case manager met with the hospital physician to discuss the resident's discharge from the hospital to the facility. The physician discussed medication changes, and future supports for the resident's medical needs. The resident returned to the facility, and was placed on one-to-one supervision. Observation on 8/27/19 at 11:15 AM showed resident #1 with one-on-one supervision. Review of the facility's policy and procedure titled "Transfer & Discharge Procedure" showed under "Criteria for Transfer or Discharge" "...A resident will not be transferred or discharged without an assessment to determine if a new plan of care would allow for the resident's needs to be met at the facility."	F 622		