

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 on 10/8/19 through 10/10/19. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set NHA- Nursing Home Administrator RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585		11/8/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/01/2019

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.

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585			

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, and review of the facility grievance log, the facility failed to ensure grievances were resolved in a timely manner for 1 of 4 sample	F 585	CORRECTIVE ACTION: Resident #34 had a grievance initiated for his missing money clip on 10/10/2019 and now has been resolved.		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 585	Continued From page 3 residents (#34) with reported grievances. The findings were: 1. Interview with the representative for resident #34 on 10/08/19 at 5:10 PM revealed the resident had a "1925 silver dollar" money clip that was broken and the facility had it fixed. After the repaired money clip was returned to the resident, it went missing. Further interview revealed the facility was "still trying to locate" the money clip. 2. Review of the grievance log showed no evidence a grievance was filed when the money clip went missing. Further review showed a grievance was filed in October 2018 related to the damaged money clip. 3. Interview with the social services assistant on 10/10/19 at 8:43 AM revealed a grievance was completed at the time the money clip had broken; however, a new grievance was not filed when the money clip went missing. Further interview revealed it was reported the money clip was being stored in the nurse's cart; however, it was not in the cart when she went to get it for the resident. 4. Interview with the administrator, social services director, and social services assistant on 10/10/19 at 11:12 AM revealed the money clip remained missing and there had been no resolution completed. They confirmed a new grievance form should have been completed and was not.	F 585	IDENTIFICATION OF OTHERS: Residents that have reported missing items have the potential to be affected by this deficient practice. No other residents have found to be affected. SYSTEMIC CHANGE: Education was provided to the Social Services department by the Administrator on 10/11/2019 related to the policy for "Truly Listening to our Customers" grievance resolution policy. Education provided to current staff by the Staff Development Coordinator or designee related to "Truly listening to our Customers" grievance resolution policy. Grievances/concerns will continue to be reviewed daily Mon-Fri in Stand Up/Stand Down meeting and resolution will be ensured. This education will be provided on or before the date of compliance. MONITORING: The Administrator will audit the Grievance/Concern Log weekly and will report any identified patterns or trends of unresolved grievance/concerns to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 4 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. §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 resident and staff interview, medical record review, and policy and procedure review, the facility failed to report an allegation of missing money to the State Survey Agency and local law enforcement for 1 of 2 sample residents (#4) reviewed for allegations of abuse, neglect and misappropriation of property. The findings were: 1. Review of the quarterly MDS assessment with an assessment reference date of 7/2/19 showed	F 609	CORRECTIVE ACTION: Resident #4's allegation of missing money was reported to the State Survey Agency on 10/10/2019. IDENTIFICATION OF OTHERS: Residents that have made allegations of missing money have the potential to be affected by this alleged deficient practice. No others were identified.		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 5 resident #4 was admitted to the facility on 10/2/18 and was cognitively intact with a BIMS (brief interview for mental status) score of 15. Interview on 10/8/19 at 3:27 PM with the resident revealed \$310 had gone missing from his/her room a couple weeks ago. The resident reported the missing money to the social services staff, and they said s/he should have locked the money up. The resident was not aware of any investigation into the missing money. The following concerns were identified: a. Interview on 10/9/19 at 4:17 PM with the social service assistant (SSA) revealed the resident told her s/he had a large amount of money. The SSA encouraged the resident to give the money to the facility and open an account. The resident stated s/he had a good hiding spot and did not wish to open an account with the facility. The SSA further stated a couple of weeks ago the resident reported money had been "stolen" but she did not fill out an incident report, or report the allegation to the administrator. b. Interview on 10/10/19 at 9:35 AM with the NHA revealed she was not aware the resident had money in the facility and was not aware of any allegation it had been misplaced or reported stolen. She stated her expectation for residents who had money was to have the facility hold the money or have the resident open a bank account in the community. Further, if there was an allegation of theft or misappropriation of property this was expected to be reported to her and investigated. c. Review of the Abuse & Neglect Prohibition policy, with a revision date 7/18, showed "...The facility will report all allegations and substantiated occurrences of...misappropriation of property to the administrator, State Survey Agency, and law enforcement officials..."	F 609	SYSTEMIC CHANGE: Education was provided to the Social Services Department by the Administrator related to the Abuse/Neglect policy and procedure. Education was provided to the current staff by the Staff Development Coordinator or designee related to the Abuse/Neglect policy and procedure. Grievances/Concerns, the 24hr Report, and Ambassador visits will continue to be reviewed in Stand Up/Stand Down meetings identifying any potential allegations not reported to the State Survey Agency as required. The Administrator or designee will interview 3 residents per week x 4 weeks to identify any potential allegations that have not been reported. This education will be provided on or before the date of compliance. MONITORING: The Administrator will report any identified patterns/trends of the random resident interviews to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 resident interview, staff interview, and policy and procedure review the facility failed to investigate an allegation of missing money for 1 of 2 sample residents (#4) reviewed for allegations of abuse, neglect and misappropriation of property. The findings were: Review of the quarterly MDS assessment with an assessment reference date of 7/2/19 showed resident #4 was admitted to the facility on 10/2/18 with medical diagnoses which included heart failure, peripheral vascular disease, septicemia, diabetes mellitus, schizophrenia, and chronic obstruction pulmonary disease. The resident was cognitively intact with a BIMS (brief interview for mental status) score of 15. Interview on 10/8/19 at 3:27 PM with the resident revealed s/he had	F 610	CORRECTIVE ACTION: Resident #4's allegation of missing money was reported on 10/10/2019 and investigated thoroughly. IDENTIFICATION OF OTHERS: Residents that have made allegations of missing money have the potential to be affected by this alleged deficient practice. No others were identified. SYSTEMIC CHANGE: Education was provided to the current staff by the Staff Development Coordinator or designee related to the Abuse/Neglect policy and procedure. Grievances/Concerns, the 24hr Report, and Ambassador visits will	11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 610	Continued From page 7 \$310 missing from his/her room a couple weeks ago. The resident reported the missing money to the social services staff, and they said s/he should have locked the money up. The resident was not aware of any investigation into the missing money. The following concerns were identified: a. Interview on 10/9/19 at 4:17 PM with the social service assistant (SSA) revealed the resident told her s/he had a large amount of money. The SSA encouraged the resident to give the money to the facility and open an account. The resident stated s/he had a good hiding spot and did not wish to open an account with the facility. The SSA further stated a couple of weeks ago the resident reported money had been "stolen" but she did not fill out an incident report, or report the allegation to the administrator. b. Interview on 10/10/19 at 9:35 AM with the NHA revealed she was not aware the resident had money in the facility and was not aware of any allegation it had been misplaced or reported stolen. She stated her expectation for residents who had money was to have the facility hold the money or have the resident open a bank account in the community. Further, if there was an allegation of theft or misappropriation of property this was expected to be reported to her and investigated. c. Review of the Abuse & Neglect Prohibition policy, with a revision date 7/18, showed "...The facility will immediately investigate and correct reported or identified situations in which abuse, neglect, injuries of unknown origin, or misappropriation of resident property is at risk for occurring...."	F 610	continue to be reviewed in Stand Up/Stand Down meetings daily Monday-Friday identifying any potential allegations not reported and investigated as required. The Administrator or designee will interview 3 residents per week x 4 weeks to identify any potential allegations that have not been reported or investigated. This education will be provided on or before the date of compliance. MONITORING: The Administrator will report any identified patterns/trends of the random resident interviews to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656			

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to develop a care plan for 2 of 18 sample residents (#9, #43). The findings were: 1. Review of the 8/19/19 annual MDS assessment showed the resident had diagnoses which included cerebral palsy, anxiety disorder, and depression. Further review showed the resident had a brief interview for mental status (BIMS) score of 15 and required extensive assistance for 2 or more people for bed mobility, transfers, dressing, toilet use, and personal hygiene. The following concerns were identified: a. Observation on 10/08/19 at 11:19 AM showed the resident utilized an electric wheelchair which was equipped with a pommel cushion (a cushion with an upward-projecting protuberance at its front part which prevents a resident from slipping down on the seat) and seatbelt in his/her wheelchair. b. Review of the ADL performance care plan on 10/8/19 showed there was no evidence the pommel cushion or seatbelt use was included on the care plan. c. Observation on 10/10/19 at 9:09 AM showed the resident was able to remove the seat belt without assistance. d. Interview with the DON on 10/10/19 at 9:17 AM revealed the resident's wheelchair was made custom for the resident and an assessment was performed with occupational therapy related to the use of the pommel cushion. e. Review of an occupational therapy	F 656	CORRECTIVE ACTION: Resident #43's care plan was developed related to his use of a Pommel cushion and self-releasing seat belt. Resident #9s care plan was developed related to Activities. IDENTIFICATION OF OTHERS: Residents that use Pommel cushions and/or self-releasing seat belts have the potential to be affected by this deficient practice. No others were identified. Residents that require Activity changes related to them sleeping more and being depressed have the potential to be affected by this deficient practice. No others were identified. SYSTEMIC CHANGE: Education to the Interdisciplinary Team was provided by the District Director of Care Management related to the requirement for Care Plan Development for each resident's individual needs. The RCMD/designee will audit 3 resident care plans weekly x 4 weeks to ensure a care plan has been developed to meet the residents' individual needs. This education will be provided on or before the date of compliance. MONITORING: The RCMD reviews these audits monthly and reports any patterns/trends to the Quality Assurance Performance Improvement Committee		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 656	Continued From page 10 evaluation dated 11/1/16 showed the resident used the electric wheelchair with pommel support cushion. Further review showed the cushion was for medial thigh support. f. Interview with the DON on 10/10/19 at 9:55 AM confirmed the resident's use of a seat belt and pommel cushion should have been on the care plan. g. Interview with the DON on 10/10/19 at 12:33 PM revealed the pommel cushion and seat belt were added to the care plan on 10/9/19. 2. Review of the medical record showed resident #9 was admitted to the facility on 7/15/19 with diagnoses that included multiple sclerosis and depression. Review of a social service note dated 8/26/19 at 3:11 PM showed the resident had been sleeping a lot and was more depressed. The note showed the activities director was consulted to for additional ideas on activities the resident may enjoy. The following concerns were identified: a. Review of the care plan on 10/8/19 showed activity pursuits were not included. b. Interview with the activity director on 10/10/19 at 11:33 AM revealed, although there was no documentation, she had visited with the resident regarding activity interests. She stated the resident was known to be more alert in the later part of the day and evenings and had shown interest in attending an evening Bingo game and watching movies. Further, the director revealed the resident received one to one conversation visits twice per week. She verified these approaches for activities were added to the care plan on 10/9/19.	F 656	monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 11 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure medications were not expired in 1 of 4 medication storage areas (special care unit). In addition the facility failed to ensure medications were labeled prior to administration during 2 of 4 medication	F 755	F755 Pharmacy Services CORRECTIVE ACTION: The expired narcotic was immediately removed from the Medication Cart. The medications that were pre-poured for administration at a later time were immediately removed.		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 12 storage observations. The findings were: 1. Observation of the special care unit (SCU) medication cart on 10/10/19 at 9:29 AM showed one multiple dose bubble pack of diphenoxylate-atropine 2.5-0 N (opioid/anticholinergic) had expired on 9/22/19. Interview at that time with RN #1 revealed the medications were for resident use and confirmed the medication had expired. 2. Observation on 10/10/19 at 9:29 AM of the SCU medication cart showed the medication in the medication cart had been removed from the pharmacy packaging and placed in individual medication cups. Two residents who were to receive medications at that time had a medication cup with the resident's name on the cup. No medications were identified on the medication cup. Interview at that time with RN #1 revealed the medications were prepared for medication administration when the residents were ready. 3. Observation on 10/10/19 at 9:54 AM of the Chapel Hall medication cart showed the medication in the medication cart had been removed from the pharmacy packaging and placed in an individual medication cup. One resident who was to receive medications at that time had a medication cup with the resident name on the cup. No medications were identified on the medication cup. Interview at that time with RN #2 revealed the medications were prepared for medication administration when the resident was ready. 4. Interview on 10/10/19 at 10:47 AM with the director of regulatory compliance revealed it was the facility expectation for staff not to pre-pour	F 755	IDENTIFICATION OF OTHERS: Current residents have the potential to be affected by this alleged deficient practice. No others were identified. SYSTEMIC CHANGE: Education provided to the licensed Nursing staff related to Proper Medication Storage prior to administration by the Staff Development Coordinator. Audits of Medication carts will be completed weekly x 4 weeks by Nursing Administration to ensure no expired narcotics exist and no pre-poured medications have been placed in carts. This education will be provided on or before the date of compliance. MONITORING: The DON or designee will report any identified patterns/trends of the medication cart audits to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 755	Continued From page 13 medications, and to destroy expired medications. 5. Review of the policy and procedure "LTC Facility's Pharmacy Services and Procedures Manual" last revised on 7/23/19, showed "... 10. Facility should ensure that the medications and biological's for each resident are stored in the containers in which they were originally received. Facility should ensure that no transfers between containers are performed by non-pharmacy personnel...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biological in accordance with Pharmacy return/destruction guidelines..."	F 755			
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by	F 801		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 801	Continued From page 14 an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the	F 801			

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 801	Continued From page 15 course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and education information review, the dietary manager qualifications were not met. The census was 75. The findings were: Interview with the dietary manager on 10/8/19 at 8:26 AM revealed he was not certified; however, had completed the education requirements to sit for a certification exam for dietary managers. Review of the educational record showed completion of on-line classes related to nutrition and Foodservice management from the University of North Dakota. In addition, the manager had a "Career Diploma" in "Gourmet Cooking and Catering." The manager verified this was not an associate's degree and he planned to take the certification exam to be qualified as a dietary manager, but the exam date had not yet been scheduled.	F 801	CORRECTIVE ACTION: A Certified Dietary Manager is now in place to mentor the current Dietary manager at least 25 hours per week until dietary manager is able to complete proper education. IDENTIFICATION OF OTHERS: No residents were cited in this alleged deficient practice. SYSTEMIC CHANGES: A Certified Dietary Manager will be in place on or before the date of compliance. MONITORING: The dietary manager will report any changes related to certification to the Quality Assurance Performance Committee as they arise for review and their direction.		
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	F 803		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 803	Continued From page 16 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 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, menu and recipe review, and staff interview, the facility failed to ensure the menu was followed for 1 of 1 meal services observation (noon meal 10/10/19). The findings were: Observation of the posting outside the main dining room on 10/9/19 showed one of the options for the noon meal was "Beef Pepper Steak with Gravy" the posting included a picture of the food item. Review of the planned menu used by the dietary staff to prepare the days meals showed the beef pepper steak and gravy was the main hot item. In addition, review of the recipe for the item showed fresh green bell	F 803	CORRECTIVE ACTION: One to one education provided by the Dietary Manager to Cook #1 related to following recipes for menus posted. IDENTIFICATION OF OTHERS: No residents were cited in this alleged deficient practice. SYSTEMIC CHANGES: Certified Dietary Manager educated cooks related to following posted menus. Certified Dietary Manager will be present at meals 5 x week for 4 weeks to ensure menus are being followed. This education will be		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 803	Continued From page 17 peppers and yellow onion were part of the ingredients. The following concerns were identified: a. Observations on 10/9/19 at 4:47 PM showed there was no pepper steak available, instead there was roast beef with no peppers or onions. b. Interview with cook #1 on 10/9/19 at 4:56 PM revealed he had not followed the recipe due to not having time to prepare the peppers and onions. c. Review of grievances related to dietary for September and October 2019 showed resolved grievances dated 9/19, 9/23 and 9/30 which included various food items not being available. d. Interview with the dietary manager on 10/9/19 at 5:09 PM verified the menu and recipes were expected to be followed.	F 803	provided on or before the date of compliance. MONITORING: The CDM or designee will report any identified patterns/trends of the meal observations to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.		
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 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,	F 880		11/8/19	

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 18 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 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.	F 880			

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 19 §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, medical record review, and staff interview, the facility failed to ensure infection control standards were met during 1 random observation involving resident #48. The findings were: Review of the quarterly MDS assessment dated 7/25/19 showed resident #48 had an indwelling catheter, and diagnoses including neurogenic bladder, obstructive uropathy, multidrug resistant organism, septicemia, urinary tract infection (UTI), cerebrovascular accident (CVA), non-Alzheimer's dementia, hemiplegia, seizure disorder, depression, sepsis due to (d/t) other specified staphylococcus, other retention of urine, dysphagia, functional dyspepsia, constipation, and personal history of UTI. The following concerns were identified: a. Observation on 10/9/19 at 11:26 AM showed, the resident was receiving care for bowel incontinence. During the care the CNAs lifted the urinary foley bag and placed it onto the foot of the bed. The tubing was noted to contain cloudy urine that was angled downward toward the resident. Continued observation showed at 11:37 AM when the CNAs left the room, the urinary foley catheter bag remained on bed. b. Interview on 10/9/19 at 11:45 AM with RN #1 revealed the catheter bag placement was	F 880	CORRECTIVE ACTION: Catheter bag for Resident #48 was immediately relocated to the frame of the bed which was below the level of the bladder. IDENTIFICATION OF OTHERS: Residents with indwelling catheters have the potential to be affected by this alleged deficient practice. No others were identified. SYSTEMIC CHANGES: Education provided to nursing staff by the Staff Development Coordinator related to the proper placement of indwelling catheter bags to assist in preventing urinary infections. The DON or designee will monitor resident catheter bag placement by random observations weekly x 4 weeks. This education will be provided on or before the date of compliance. MONITORING: The DON will report any identified patterns/trends of the random resident catheter bag placements to the Quality Assurance Performance Improvement Committee monthly for their review and resolution. This tracking will continue for 3 months unless the Quality		

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

PRINTED: 11/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2019
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 20 expected to be on the frame of the bed and below the level of the resident's bladder. The bag should not be on the floor or lying on the bed. c. Observation on 10/09/19 at 11:52 AM showed RN #1 drained the foley tubing back into the bag and then secured the bag to the side of bed not touching the floor.	F 880	Assurance Performance Improvement Committee deems it prudent to continue.		