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 02/13/2020

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 2/11/20 through 2/13/20. The survey was prompted by complaint intake WY00003025. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide MDS- Minimum Data Set LPN- Licensed Practical Nurse PRN- Pro re nata (as needed) QAPI- Quality Assurance Performance Improvement Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and facility record review, the facility failed to ensure accident hazards were identified and eliminated for 1 of 5 sample residents (#5) reviewed for incidents. This failure resulted in harm for resident #5, who suffered a burn. Correction measures were implemented by	F 689	Past noncompliance: no plan of correction required.	3/9/20

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

Electronically Signed | 03/09/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 the facility and compliance was determined to have been met on 1/13/20. The findings were: Review of the medical record for resident #5 showed an admission date of 2/4/19 with diagnoses that included venous insufficiency (chronic, peripheral), age-related debility, history of fracture, pressure ulcer stage 2, adult failure to thrive, peripheral vascular disease, and abnormal weight loss. Review of the Significant Change MDS assessment dated 1/27/20 showed a brief interview for mental status score of 5, indicating severe cognitive impairment. Review of the nursing note dated 1/11/20 and timed 11:27 PM showed "Upon entering the room to administer [the resident's] PRN acetaminophen, I found both [his/her] feet resting on the heater. I then removed [the resident's] feet from the heater and noted it was not hot to touch. Assessing [the resident's] feet I found no abnormal warmth, visual inspection revealed no new skin tears, redness, or abnormal signs. I then placed [his/her] feet down on the bed and tucked the blanket under them." Review of the nursing note dated 1/12/20 and timed 12:23 AM showed the nurse "...entered resident's room and visually identified that resident's feet were under [his/her] blanket and resident was resting comfortably." Interview with LPN #1 on 2/12/20 at 11:57 AM revealed the resident was typically cold and usually requested at least three blankets. The LPN further stated, "This is the first time I have seen [the resident] put feet on the heater." Interview on 2/12/20 at 3:58 PM with CNA #1 revealed the resident had put his/her feet on the heater the first night after they had rearranged the room two months ago, stating, "That night I	F 689		

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F 689	Continued From page 2	F 689		

removed [his/her] feet from the heater two or three times. I normally do my rounds at least four times a night." The CNA stated the resident had not put his/her feet on the register since that first night. The following concerns were identified:

1. Review of the nursing note dated 1/12/20 and timed 10:06 AM showed "It was reported to this nurse by nursing assistant that resident had a large wound on [his/her] right lateral ankle and foot. This nurse then immediately assessed the resident, who was in bed lying supine, call bell cord in place and alert x3. Resident denied any pain and was not in any distress or immediate danger. Wound reported to nurse manager on duty."

2. Review of physician notes for resident #5 dated 1/13/20 showed "Unfortunately, the night before last, [the resident] suffered a burn to the lateral portion of [his/her] right foot and heel after laying [his/her] foot on the heater repeatedly throughout the night...ASSESSMENT AND PLAN: 1. Superficial burn to the right ankle. 2. Peripheral vascular disease."

3. Observation of the dressing change for resident #5 on 2/12/20 at 11 AM showed a burn measuring approximately 6 centimeters (cm) long by 2 cm wide. There were two focal sites, each 2 cm in diameter which showed debriding skin with a red base and pink healing rims. The area was dressed using sterile technique with medihoney to the area of sloughing and calcium silver alginate to the area of red granular tissue.

Review of the facility's corrective measures showed the following:

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F 689	Continued From page 3 a. Resident #5's room was rearranged so that the bed was not next to the register making it impossible for the resident to place his/her feet on the register. The maintenance director assessed the heat register and verified that it was operating appropriately. b. An audit of all residents with beds next to heat registers was performed. All rooms were rearranged to remove the hazard on 1/13/20. This constituted 15 of 81 beds. All heat registered were evaluated on 1/13/20. The highest temperature recorded was 103 degrees Fahrenheit. Environmental expectation is that no register exceed 108 degrees F. and all beds be at least 8 inches from heat registers. c. Nursing and therapy staff were educated on risk for entrapment and injury based on bed placement. Housekeeping was documented as training 9 staff on 1/13/20. Further review showed documentation of 73 staff members receiving training. d. The interdisciplinary team held an ad hoc meeting related to the potential for resident burns from in-room heat registers on 1/13/20. Review of the QAPI meeting agenda showed the topic was addressed on 1/29/20.	F 689		