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 02/16/2021

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 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 2/9/21 to 2/16/21. The survey was prompted by complaint intakes WY000003126, WY000003040, and WY000003029. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by healthcare licensing and surveys at that time. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing Services Less commonly used abbreviations will be annotated in each deficiency.	F 000		
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	F 600		3/18/21

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

Electronically Signed | 03/12/2021

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F 600	Continued From page 1 by: Based on staff interview, review of facility investigation, medical record review, and policy and procedure review, the facility failed to ensure 1 of 3 sample residents (#1) was free of abuse. The findings were: 1. Review of the "Behavior" care plan last revised on 1/6/21 showed resident #1 had an "alteration in mood/well being" related to a diagnosis of Alzheimer's dementia. Review of the "Skin Integrity" care plan last revised on 1 8/21 showed the resident "will sometimes become combative during cares and start waving [his/her] arms/hands or hitting at staff potentially hitting the wall, wheelchair, etc..." Review of a progress note dated 9/21/20 and timed 12 PM showed the resident was "lethargic first thing this morning and respiratory status changed significantly from before breakfast to before lunch." The resident was placed on 2 L of oxygen to maintain an oxygen saturation of 93%. Review of a progress note dated 9/21/20 and timed 2:04 PM showed the facility contacted the resident's family related to the resident's status and family requested the facility take the resident to the hospital or urgent care. Review of a progress note dated 9/21/20 and timed 3:45 PM showed the resident was transported, via the facility van, to urgent care. The following concerns were identified: a. Review of a facility incident report dated 9/21/20 showed the local police department contacted the facility to report an allegation of verbal abuse from the van driver toward resident #1. Further review showed the facility spoke with the police department on 9/22/21, and were told an officer received a call which alleged the facility van driver called the resident names and slammed the bus door prior to taking the resident	F 600	Corrective Action: This employee was terminated due to this incident. ID of others: Review of verbal abuse allegations during the previous 30 days to ensure appropriate guidelines were followed. Systemic Change: NHA/designee will provide education on abuse and neglect to all staff. Monitoring: The Administrator will report any identified patterns/trends of that month□s reportable events 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. NHA/designee will review resident rights during the resident council meeting for the next 3 months. Council minutes will be reviewed in QAPI to ensure compliance.	

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F 600	Continued From page 2 into the urgent care. Review of an interview completed by the facility with the van driver on 9/22/20 showed the van driver reported the resident hit him in the face and the van driver told the resident "Look here you son of a bitch, I'm here to help you." b. Interview with the former facility van driver on 2/10/20 at 1:10 PM revealed when he was strapping the resident into the van, the resident was combative and hit the van driver in the ribs. After arriving at the urgent care, the resident was physically aggressive while the van driver attempted to remove the straps. The van driver stated the resident hit him in the face and "ripped off" the van driver's mask and glasses. The van driver stated he stepped away from the resident and said "Listen here, you son of a bitch, don't touch me." The van driver confirmed he was suspended pending investigation and terminated from the facility related to the incident. c. Interview with the administrator on 2/10/21 at 1:50 PM revealed the van driver was suspended and terminated related to the incident. Further interview revealed the facility did not implement a plan of correction following the incident. d. Review of the policy titled "Abuse and Neglect Prohibition Policy" provided by the facility on 2/16/20 showed "...Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property...Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability..."	F 600		
F 880 SS=D	Infection Prevention & Control	F 880		3/16/21

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F 880	Continued From page 3 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, 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	F 880		

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F 880	Continued From page 4 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. §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, staff interview, staff education review, and review of the Centers for Disease Control (CDC) guidelines, the facility failed to ensure personal protective equipment was used appropriately in 1 of 5 units (COVID positive dementia unit). The findings were: 1. Observation of the COVID positive dementia unit on 2/9/20 at 6:19 PM showed CNA #1 was wearing 2 N95 masks which created a gap	F 880	Corrective Action: The facility will immediately implement and appropriate infection preventions and intervention plan consistent with the requirements of 483.80 for the affected unit identified in the deficiency. The Infection Preventionist and Director of Nursing, in conjunction with the medical director, shall complete the following:	

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F 880	Continued From page 5 between the CNAs masks and cheeks bilaterally. Interview with CNA #1 on 2/9/20 at 6:28 PM confirmed she was wearing 2 N95 masks and revealed she heard it was recommended for people to double mask. 2. Interview with the DON on 2/10/20 at 10:55 AM revealed the facility did not encourage double masking and staff should not wear 2 masks at one time in the facility. 3. Review of a one to one education sheet dated 2/10/21 showed the DON performed education with CNA #1 which included "Double masking is not encouraged in the healthcare setting as the appropriate and tested use of the mask (surgical and N95) are based on single use masks (one at a time)." 4. Review of the CDC guidance titled "Improve How Your Mask Protects You" updated 2/13/21 showed "...Make sure your mask fits snugly against your face. Gaps can let air with respiratory droplets leak in and out around the edges of the mask..."	F 880	1.) Develop and implement face mask and suitable face covering procedures for staff and residents in communal areas of the secure unit. ID of Others: The IP and DON, in conjunction with the interdisciplinary team will review current COVID-19 nursing facility guidelines from the CDC and CMS. The IP, DON, and applicable IDT members will evaluate the facility's overall compliance with the guidelines. The facility will develop action plans to address and newly identified non-compliance. Guidelines for COVID-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Systemic Change: On or before 3.16.21 the facility shall complete the following areas: 1.) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure face mask or suitable face covering for staff and residents in communal areas of the facility were implemented. 2.) Failure to ensure staff with reported symptoms did not continue to work in the facility. The DON and IP will ensure that education is provided for the following:	

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F 880	Continued From page 6	F 880	a. All staff are educated on the need for use of face masks or other suitable face coverings when in common areas and while providing care in the facility. 3.) The facility leadership will contact Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection and prevention and control within the facility. Monitoring: Monitoring of approaches to ensure infection control and prevention are effective will include: 1.) Weekly for no less than 12 weeks, the IP, DON, and applicable IDT will conduct ongoing monitoring via observation to ensure staff are complying with requirements for: a. Compliance with face masks or suitable face coverings when in common areas or receiving care. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than 3 months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes 3 consecutive rounds of monthly monitoring which demonstrates sustained compliance as	

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F 880	Continued From page 7	F 880	approved by the QAPI committee and medical director.	