STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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 PRECEEDED 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
K 000	INITIAL COMMENTS Surveyor #18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with an automatic supervised dry sprinkler system and fire alarm system. K6: Date of Plan Approval: 1962 and 1988 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=128;SNF/NF=128 K9: The facility meets the Life Safety Code standards based on an acceptance of a Plan of Correction. "NFPA" National Fire Protection Association	K 000	POC ACCEPTED W/ DONNA SCHULZ ON 11/2/06 @ 10:45AM.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Donna Schulz	Administrator	10-23-06

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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 PRECEEDED 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
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 10/03/06 between 9 AM and 10 AM revealed the following corridor doors did not fit tight into the frame to resist the passage of smoke. a. Resident room #510. b. The staff lounge.	K 018	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG K018 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide doors which resist the passage of smoke. 1. The maintenance staff has reduced the gap between the door and frame with heat resistant felt. 2. The maintenance staff will inspect all corridor doors for proper fit in the frame. Any door with greater than the minimum clearance necessary for proper operation will be modified to fit tight in the frame. 3. All corridor doors will be inspected by the Maintenance Department quarterly in the preventive maintenance program. 4. The Safety Committee will review Quarterly maintenance checks and randomly audit corridor door fit. Any deviation from standard will be reported to the Administrator for follow-up.	11/03/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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 PRECEEDED 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
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations the facility failed to protect 6 of 16 smoke barrier doors in accordance with NFPA 101 Section 19.3.7.3 and 4.6.12.2. The findings were: 1. Observation on 10/03/06 between 8:30 AM and 11 AM revealed the following smoke barrier double doors were equipped with latching devices which were not able to fully latch the doors into the frames: a. The smoke barrier doors near resident room #120. b. The smoke barrier doors near the east wing lobby. c. The smoke barrier doors near the north nurses station.	K 027	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG K027 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide smoke barrier doors which fully latch in their frames 1. The latches on smoke barrier doors by room 120, East Wing Lobby and North Station have been adjusted So that doors latch in their frames. 2. The Maintenance staff will inspect all smoke barrier doors to assure that all doors latch in their frames. 3. All smoke barrier doors will be inspected for proper latching by the maintenance staff monthly in the preventive maintenance program. 4. The Safety Committee will review maintenance checks and randomly audit smoke barrier doors for proper latching. Any deviations from standard will be reported to the Administrator for follow-up.	11/03/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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

11/2/06

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to separate 4 of 19 hazardous areas from other spaces by smoke-resistant assemblies in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 10/03/06 at 8:10 AM revealed the clean utility room corridor door near resident room #120 was impeded from closing by a wood wedge. 2. Observation on 10/03/06 at 9:31 AM revealed the west boiler room had four unsealed pipe penetrations in the east wall. 3. Observation on 10/03/06 between 8 AM and 9:30 AM revealed the following locations were storing excessive amounts of combustibles without the required 1-hour fire rated separation: a. The copy room was storing 10 boxes of printer paper. b. The Alzheimer unit tub room was being used as a linen storage room.	K 029	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG K029 – PLAN OF CORRECTION** It is the policy and practice of this facility To protect hazardous areas. 1. The wooden wedge at the Utility Room has been discarded, pipe penetrations in the boiler room have been sealed , printer paper has been removed from the copy room. The Alzheimer's Unit tub room is equipped with self closing smoke resistant door. 2. All staff will be inserviced on the requirement to keep doors to utility rooms and storerooms closed and not to block doors open with wedges. 3. Utility rooms, storage rooms and copy room will be inspected for proper door closure and/or combustible load by the maintenance department monthly. 4. The Safety Committee will review the monthly maintenance checks and randomly audit door closures. Any deviations from standard will Be reported to the Administrator for follow-up.	11/03/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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 PRECEEDED 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
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain an egress corridor system unobstructed and accessible at all times in accordance with NFPA 101 Section 19.2.1 and 7.1.10.1. The finding was: 1. Observation on 10/03/06 between 8 AM and 12 PM revealed a reclining chair was left in the corridor near the maintenance office throughout the survey, including the fire drill.	K 038	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG K038 – PLAN OF CORRECTION** It is the policy and practice of this facility to maintain an egress corridor system unobstructed and accessible at all times. 1. The maintenance department employees will be inserviced on clearing the hallway in front of their work area. 2. The Staff Development Coordinator will inservice all staff on the requirement of keeping hallways clear of obstructions. 3. The clearance of corridors will be noted with each quarterly fire drill. Staff will be re-inserviced as needed. 4. The Safety Committee will review fire drill reports for trends and satisfactory performance.	11/03/06
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations the facility failed to provide an electrical system installed in accordance with NFPA 70 Section 400-8. The findings were: 1. Observation on 10/03/06 between 8 AM and 11 AM revealed the following location had temporary electrical wiring replacing permanent fixed wiring due to insufficient electrical receptacles: a. The air conditioning unit in the Alzheimer unit was being supplied with power by an extension	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/03/2006

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 PRECEEDED 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
K 147	Continued From page 5 cord. b. The copy room had a surge protector plugged into a 3-way adapter. c. The beauty shop had three circling irons plugged into a 3-way adapter.	K 147	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. **TAG K147 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide electrical service in compliance with the electrical code. 1. An electrical outlet will be added for the air conditioner. Additional outlets will be added to the copy room and beauty shop to eliminate the need for 3-way adapters. 2. All areas of the building will be inspected to identify areas needing installation of additional electrical outlets. 3. The maintenance department and housekeepers will be inserviced on being observant of electric outlets on an on-going daily basis. 4. The Safety Committee will perform quarterly audits of the building. Any excess use of outlets or use of extension cords will be reported to the Administrator for follow-up.	11/03/06