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

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 _____	04/10/2012

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

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinkled single story building of Type V (111) construction built in 1962 and 1988. The building was equipped with a supervised automatic dry sprinkler system and an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 90.	K 000	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 the 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. This plan of correction serves as the facility's allegation of compliance.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 8 smoke barrier walls was smoke resistant. The findings were: Observation of the chapel hall attic smoke barrier	K 025	**Corrective Action:** The identified self-closing spring has been re-installed. The identified 2 inch by 4 inch pipe penetration has been sealed. **Identification of Others:** An audit of the facilities smoke barrier walls was completed and all identified issues were repaired. **Systems/Measures:** Annual and as needed preventative maintenance audits will be completed on all smoke barrier walls to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway | TITLE: administrator | (X6) DATE: 04/26/2012

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.

POC ACCEPTED w/ DAVID CONAWAY, NHA, DN 5/7/12

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K 025	Continued From page 1 wall on 4/10/12 at 11:40 AM showed the self-closing (spring) device for the smoke barrier door had been removed. Further observation showed an unsealed pipe penetration that measured 2 inches by 4 inches. At the time of the observation the maintenance director reported she was unaware when the spring was disconnected from the door. She also reported the barriers were inspected semi-annually, but had not been inspected since November 2011.	K 025	of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3.	05/16/12
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 observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 9 smoke compartments. The findings were: Observation of the west central exterior canopy on 4/10/12 at 10:26 AM showed two propane tanks with a 5 gallon capacity were stored under the canopy. Further observation showed the canopy had sprinkler coverage but two resident	K 029	**Corrective Action:** The two identified gas grill propane tanks with a 5-gallon capacity have been removed. **Identification of Others:** An audit of the facility was completed and all identified issues addressed immediately. **Systems/Measures:** Monthly preventative maintenance audits of the building will be completed to ensure compliance with standards. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee. The QA&A committee will evaluate the effectiveness of the plan based on	

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K 029	Continued From page 2 room windows looked onto the canopy. At the time of the observation the maintenance director reported she was unaware new storage locations required 1-hour separation and sprinkler coverage.	K 029	trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	05/16/12
K 038 SS=E	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 observation and staff interview, the facility failed to ensure egress pathways were unobstructed in 1 of 9 smoke compartments. The findings were: Observation of the special care unit (SCU) courtyard on 4/10/12 at 10:38 AM showed the exterior gate was locked with a keyed padlock. At the time of the observation the maintenance director reported the maintenance staff and SCU resident care unit managers were the only people that carried keys to this lock. She also reported that she was unaware all staff members of the SCU were required to carry a key to any keyed lock in the means of egress. Reference, NFPA 101, 2000 Edition; 19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of	K 038	**Corrective Action:** The identified keyed padlock has been removed. It has been replaced with a combination lock. The locks combination has been engraved on the back of the lock to ensure that all staff could pass through the exterior gate. Staff will be in serviced regarding the operation of the combination lock. **Identification of Others:** An audit of the facility was completed and all identified issues address. **Systems/Measures:** Annual and as needed preventative maintenance audits will be completed in and out of facility to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee. The QA&A will evaluate the effectiveness of the plan based on trends identified and implement additional	

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K 038	Continued From page 3 locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.	K 038	interventions as needed to ensure continued compliance.	05/16/12
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the emergency generator and emergency battery lights were tested for 2 of the past 12 months. The findings were: Review of the egress lighting system showed the corridor door lights were supplied with power from the emergency generator. Review of the generator testing records showed the monthly full load transfer test had not been conducted during November 2011 and January 2012. Review of the emergency battery light testing records showed the monthly 30 second test had not been conducted during November 2011 and January 2012. On 4/9/12 at 6:15 PM the maintenance director confirmed the tests had not been conducted during the aforementioned months. Reference, NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully	K 046	**Corrective Action:** The monthly full load transfer test has been completed. The monthly emergency battery light 30-second test has been completed. **Identification of Others:** This issue has been identified and only affects the two generators and the emergency battery light in each area where the generators are located. **Systems/Measures:** Monthly preventative maintenance inspections will be completed on generators and emergency battery lights to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee by the maintenance director and/or designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional	

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K 046	Continued From page 4 operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 6.4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.	K 046	interventions as needed to ensure continued compliance monthly x3.	05/16/12
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all exterior doors were appropriately marked in 1 of 9 smoke compartments. The findings were: Observation of the Ritz dinning room on 4/10/12 at 9:40 AM showed the double glass doors lead to a patio area. Further observation showed the doors were not posted with an exit sign or a no exit sign. At the time of the observation the maintenance director reported the doors were not a required exit. She could not explain why the doors had not been signed with a no exit sign as several other doors in the facility had been signed. Reference, NFPA 101, 2000 Edition, 19.2.10.1; 7.10.8.1* No Exit. Any door, passage, or stairway	K 047	**Corrective Action:** A "NO EXIT" sign has been installed above the identified double glass doors leading to the patio area according to NFPA guidelines. **Identification of Others:** An audit of the facilities egress doors will be completed and all identified issues addressed. **Systems/Measures:** Preventative maintenance audits will be completed on facility egress doors to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to	

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K 047	Continued From page 5 that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 047	ensure continued compliance monthly x 3.	05/16/12
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure fire drills were held at varying times on 3 of 3 shifts. The findings were: Review of the fire drill records showed the facility was conducting a fire drill on all three shifts during each month. Further review showed fire drills were held on the same day for all three shifts during the months of February and March 2012. On 4/9/12 at 6:15 PM the maintenance director reported she was unaware fire drill must be conducted at unexpected times.	K 050	**K 050** **Corrective Action:** Fire drills were conducted on all three shifts monthly. Fire drills will be completed at varying times. **Identification of Others:** This issue has been identified for only two months. Fire drills will be completed at varying times and at a minimum once per shift per quarter. **Systems/Measures:** Monthly audits of the fire drill records will be completed x 3 to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	05/16/12

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K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the liquid oxygen transfer location had proper separation. The findings were: Observation of the liquid oxygen storage area on 4/10/12 at 9:13 AM showed the transferring of liquid oxygen occurred outside next to the building. Further observation showed the four cylinders were stored on a sheet of plywood not a concrete or ceramic floor. The area was located 5 feet from a door that opened onto the corridor and the door had a glass panel. The area was not protected with sprinkler coverage. At the time of	K 143	**Corrective Action:** The liquid oxygen transfer process will occur inside of the oxygen storage room to ensure proper separation. The plywood storage surface has been removed. The liquid oxygen containers have been moved to the oxygen storage room. **Identification of Others:** This issue has been identified and only affects this identified area of oxygen storage. **Systems/Measures:** Monthly preventative maintenance inspections will be completed to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee by the maintenance director and/or designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	05/16/12

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K 143	Continued From page 7 the observation the maintenance director reported she was unaware the storage area required 1-hour separation from resident use areas, a concrete floor, and sprinkler coverage.	K 143	**K 147** **Corrective Action:** The identified junction box near room #118 had a cover re-installed. The identified power cord to bed "A" in room #513 has been replaced. The identified extension cord in room #404 has been removed. **Identification of Others:** An audit of the facility's smoke compartments was completed and all identified issues were addressed. **Systems/Measures:** Annual and as needed preventative maintenance audits will be completed in all smoke compartments to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QA&A committee by the maintenance director and/or designee. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	05/16/12
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 observation and staff interview, the facility failed to ensure junction boxes were provided with covers, failed to ensure damaged electrical equipment was replaced, and failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 3 of 9 smoke compartments. The findings were: 1. Observation on 4/10/12 at 8:53 AM showed the junction box in the corridor ceiling near resident room #118 did not have a cover. At the time of the observation the maintenance director could not explain why the cover was missing. 2. Observation of resident room #513 on 4/10/12 at 10:02 AM showed the power cord to bed "A" was damaged at the plug with exposed inner wires. At the time of the observation the maintenance director could not explain why the damaged cord had not been noticed and replaced during the monthly inspections. 3. Observation of resident room #404 on 4/10/12 at 10:13 AM showed the television set was plugged into an extension cord. At the time of the observation the maintenance director could not	K 147		

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K 147	Continued From page 8 explain why the cord had not been noticed and removed during the monthly inspections. Reference, NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 90-7 Examination of Equipment for Safety. ...It is the intent of this Code that factory-installed internal wiring or the construction of equipment need not be inspected at the time of installation of the equipment, except to detect alterations of damage ... 370 28. Pull and Junction Boxes. (3) (c) cover. All pull boxes, junction boxes and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use.... 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		