RECEIVED
WY Dept of Health
JUN 18 2013
Healthcare Licensing and Surveys

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	05/22/2013

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 sprinklered, single story building with a basement of Type V (111) construction built in 1962 and 1988. The building was equipped with a supervised, automatic dry sprinkler system with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 70 residents.	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 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.	K 018	**K 018** **Corrective Action:** The identified nurse's station door latch has been repaired and is operational. **Identification of Others:** An audit of facility doors was completed and all identified issues were repaired. **Systems/Measures:** Annual and as needed preventative maintenance audits will be completed of facility doors to ensure compliance with standard.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David L. Conaway	Administrator	06/14/2013

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, ON 6/20/13

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of the chapel hall nurse's station on 5/21/13 at 3:10 PM showed the corridor door was not able to fully latch into the door frame. The latch bolt was not able to insert into the strike plate. At the time of the observation the maintenance director could not explain why the door was not noticed and repaired during the monthly safety inspection.	K 018	**Monitoring:** Maintenance Director/designee will monitor for compliance. Data obtained by way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to facility QAPI committee. QAPI committee will evaluate based on trends identified and interventions as needed to ensure continued compliance monthly x3.	~~5/22/2013~~ 5/23/13
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 2 of 3 inspected smoke barriers were smoke resistant. The findings were:	K 025	**K 025** **Corrective Action:** The identified 4-inch pipe has been sealed. The identified 2-inch x 4-inch cable penetration has been sealed. **Identification of Others:** An audit of the facility 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 standards.	

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K 025	Continued From page 2 1. Observation of the east wing smoke barrier on 5/22/13 at 8:55 AM showed there was a ½ inch gap around a 4 inch pipe penetration, in the attic. At the time of the observation the maintenance director reported smoke barriers were not routinely inspected to ensure they were smoke resistant. 2. Observation of the central smoke barrier on 5/22/13 at 9:07 AM showed a 2 inch by 4 inch unsealed cable penetration. At the time of the observation the maintenance director reported smoke barriers were not routinely inspected to ensure they were smoke resistant.	K 025	**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 QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	5/24/2013
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 1 of 2 emergency battery light test was conducted. The findings were: Review of the emergency battery light testing records showed the annual 90 minute test had not been conducted in the past year. On 5/22/13 at 9:55 AM the maintenance director confirmed the facility did not have a record to review. She reported that she was unaware of the 90 minute annual test. Reference NFPA 101, 2000 Edition, 19.2.9.1; 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted	K 046	**K 046** **Corrective Action:** The annual 90 minute emergency battery light test has been completed. **Identification of Others:** This issue has been identified and only affects the two emergency battery lights located in the generator rooms. **Systems/Measures:** Monthly preventative maintenance inspections and related tasks will be completed on the emergency battery lights which will include an annual 90 minute test. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way	

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K 046	Continued From page 3 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 1-1/2 hours. Equipment shall be fully 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.	K 046	of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QAPI committee. The QAPI 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.	5/30/2013
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to ensure 1 of 6 sprinkler system test was conducted and failed to ensure two spare sprinkler heads were maintained for each type installed. The findings were: 1. Review of the sprinkler system testing records showed the facility did not have the record of the last 3 year's full flow dry sprinkler system test. On 5/22/13 at 9:55 AM the maintenance director confirmed the facility did not have a full flow dry system record to review. She reported that she assumed the contractor would conduct the needed tests. 2. Observation of the east basement sprinkler riser on 5/22/13 at 10:10 AM showed the facility	K 062	**K 062** **Corrective Action:** A full flow dry sprinkler system test has been completed. Six spare extended coverage 150 degree sprinkler heads have been ordered and will arrive 6/17/13. **Identification of Others:** An audit of facility sprinkler heads was completed. All identified issues were addressed. **Systems/Measures:** Annual and as needed preventative maintenance audits will be completed to ensure spare types of sprinkler heads are available for immediate use to ensure compliance with standard. **Monitoring:** Maintenance director and/or designee will monitor for compliance. Data obtained by way	

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K 062	Continued From page 4 did not have any extended coverage 150 degree sprinkler heads, to replace the heads in the east resident rooms. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1999 Edition; 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit. 2-4.1.5 The stock of Spare Sprinklers shall be as follows: (a) ...Under 300 sprinklers - no fewer than 6 sprinklers (b) ...300-1000 sprinklers - no fewer than 12 sprinklers (c) ...Over 1000 sprinklers - no fewer than 24 sprinklers 9-4.4 Dry Pipe Valves/Quick-Opening Devices. 9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service.	K 062	of preventative maintenance audits will be analyzed for patterns and trends reported monthly to the facility QAPI committee by the maintenance director and/or designee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	6/14/2013
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower	K 074	**K 074** **Corrective Action:** The identified window curtains have been removed. **Identification of Others:** An audit of the facility curtains was completed and all identified issues were corrected.	

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K 074	Continued From page 5 curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure window curtains were flame retardant in 1 of 9 smoke compartments. The findings were: Observation of the social services office on 5/21/13 at 2:31 PM showed the two window curtains were not provided with flame retardant documentation. At the time of the observation the maintenance director reported the facility did not have a log showing flame retardant solution has been applied to loose hanging fabrics.	K 074	**Systems/Measures:** Annual and as needed preventative maintenance audits will be completed on all curtains in the 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 QAPI committee. The QAPI 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.	5/24/2013
K 147 SS=E	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:	K 147	**K 147** **Corrective Action:** The identified temporary power taps in rooms #422, #404, and the six way adaptor in room #116 have been removed.	

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K 147	Continued From page 6 Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 9 smoke compartments. The findings were: Observation of the electrical system on 5/21/13 between 2 PM and 5 PM showed the following locations had temporary power taps in use: a. Resident room #422 had an oxygen concentrator plugged into a 6-way power tap. b. Resident room #404 had a television plugged into a 6-way power tap. c. Resident room #116 had a radio plugged into a 6-way adapter. On 5/21/13 at 2:28 PM the maintenance director reported she was unaware power taps were not surge protectors. She confirmed the aforementioned locations had power taps in use and not permitted surge protectors. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 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	**Identification of Others:** An audit of the facility permanent fixed wiring was completed and identified issues were repaired. **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 QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	5/23/2013
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of	K 211	**K 211** **Corrective Action:** The two identified ABHR dispensers have been relocated away from any electrical ignition source.	

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

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K 211	Continued From page 7 rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not placed over ignition sources in 2 of 9 smoke compartments. The findings were: Observation on 5/21/13 between 2:30 PM and 4:30 PM showed the following locations had ABHR dispensers installed over electrical ignition sources: a. The ABHR dispenser in resident room #420 was installed over a light switch. b. The ABHR in the east wing dining room was installed over an electrical outlet. On 5/21/13 at 2:40 PM the maintenance director confirmed she was aware ABHR dispensers were prohibited from being installed above ignition sources. She could not explain why the aforementioned dispensers were installed over electrical sources.	K 211	**Identification of Others:** An audit of facility rooms that have ABHR dispensers was completed and identified dispensers have been relocated appropriately. **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 QAPI committee by the maintenance director and/or designee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x3.	5/23/2013