PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
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 with an addressable fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 83	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by:	K 017		8/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Bruce Allison	Administrator	08/06/2014

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.

Modified POC Accepted by Phone Call with Bruce Allison (Administrator) on 9/17/14 @ 8:13 am
10/3/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 017	Continued From page 1 Based on observation and staff interview, the facility failed to ensure walls and ceiling were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of rooms 408, 415, and the server closet on the 400 hall on 07/08/14 from 1:17 PM to 1:40 PM revealed several penetrations in the ceiling and walls. At the time of the observations, the Administrator acknowledged the penetrations.	K 017	K 017 Corrective Action: rooms 408,415 and the closet on hall 400 penetration holes have all been filled with Fire Barrier Foam Sealant CP 25 WB+. By Maintenance staff. Identification of Others: An audit of all rooms408,415 and closet on hall 400 were identified issues were repaired. System Measures: Annual and as needed preventative maintenance audits will be completed of all facility rooms to ensure compliance with standard. Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the 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.	
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	K 018		8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 018	Continued From page 2 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 observation and staff interview, the facility failed to provide a suitable means for keeping the doors closed which accessed the egress corridors closed in 1 of 9 smoke compartments. The findings were: Observation of the Therapy Gym on 07/09/14 at 9:05 AM revealed (2) sets of pair of doors. The inoperable door leafs were provided with manual top and bottom bolts to secure the doors in the frame. The operable door leafs would not latch and remain closed when the top and bottom bolts were not engaged. At the time of observation, the Facility Maintenance Manager acknowledged the hardware issue. REFERENCES NFPA 101 Life Safety Code, 2000 Edition 19.3.6.3.2 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction.	K 018	K 018 Corrective Action: The identified Therapy Gym doors are scheduled to have top and bottom door latch mechanisms replaced. The latches have been ordered, and will be replaced by maintenance staff. Identification of Others: An audit of the Therapy Gym doors will be conducted weekly until the identified issue is corrected. Systems/Measures: Annual and as needed preventative maintenance audits will be completed of facility doors to ensure compliance with standard. monitoring:	

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1961 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
K 018	Continued From page 3 The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.2. Exception No.1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No.2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	Maintenance Director/designee will monitor for compliance. Data obtained by the 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 month X3	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure exit signage was visible from any direction of exit access. The findings were: Observation of the exit access corridors adjacent	K 022	K022 Corrective Action: 6 illuminated exit signs have been ordered. Exit signs are hard wired and	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 022	Continued From page 4 to the Patio Dining Room on 07/08/14 and 07/08/14 throughout the survey revealed exit signage that was both internally illuminated and externally illuminated. Because of the exit signages' locations on one side of the paired cross-corridor smoke barrier doors, some of the exit signage would not be readily visible once these doors automatically closed in case of fire alarm activation. In some cases, the exit signage lacked directional indicators and the direction of travel to reach an exit was not apparent. At the time of the observation, the Facility Maintenance Manager acknowledged another AHJ had required additional exit signage to be added to this area and acknowledged the visibility and directional issues outlined above. REFERENCES NFPA 101 Life Safety Code, 2000 Edition 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location	K 022	have battery back up installed in each unit. All exit signs will be installed by certified electrician. The signs will be installed upon delivery. Identification of Others: An audit of the facility exit signs was completed and all identified issues have been addressed. 6 illuminated exit signs have been ordered and will be installed. System Measures: Monthly and as needed preventative audits will be completed of facility exit lights to ensure compliance with standard. Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the way of preventative Maintenance audits will be analyzed for patters 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	

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 022	Continued From page 6 where the direction of travel to reach the nearest exit is not apparent. 7.10.5 Illumination of Signs. 7.10.5.1 * General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 022		
K 029 SS=D	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 other spaces by smoke-resisting partitions and doors. The findings were: Observation of the interior generator room door on 07/08/14 at 3:06 PM revealed the door was tied open preventing the self-closing device from functioning and rendering the door not to be self-closing or automatic-closing. At the time of	K 029	K029: Corrective Action: Staff has been educated to using ties to prevent self-Closing devices from funtioning And rendering the door not to be self closing or automatic-closing door. Identification of Others:	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 029	Continued From page 6 the observation, the Facility Maintenance Manager acknowledged the door was tied open. REFERENCES NFPA 101 Life Safety Code, 2000 Edition 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing.	K 029	The generator room will be inspected Monthly by Maintenance Director/ other; Maintenance staff to ensure that there is no obstruction that would prevent the Doors from closing automatically. Systems/Measures: Director of Maintenance will be Responsible to ensure compliance With this standard is completed. Monitoring: Maintenance Director/ designee will Monitor for compliance. Data Obtained by the 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.	
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 observation and staff interview, the facility failed to provide exit access that was free of all obstructions to full instant use. The findings were: Observation of the exit doors on the 400 and 500	K 038	K038 Corrective Action: Venetian blinds have been removed by maintenance staff and window film has been added for privacy. The panic bars on	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 038	Continued From page 7 wings on 07/08/14 at 1:15 PM and 2:17 PM revealed venetian blinds impeded the use of the panic bars on the exit doors. At the time of the observation, the Administrator acknowledged he was unaware of this requirement. REFERENCES NFPA 101 Life Safety Code, 2000 Edition 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.2 Furnishings and Decorations in Means of Egress. 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.	K 038	the doors are free from any obstruction. Identification of Others: An audit of facility doors was completed and all identified issu were repaired. System Measures: Annual and as needed preventative maintenance audits will be completed and all identified issues were repaired. Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the 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.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on review of fire alarm testing and maintenance records and staff interview, the facility failed to provide documentation identifying required fire damper testing. The findings were:	K 067	Corrective Action: Fire Damper Testing was completed On 8/16/14. The dampers were found to be fully functional of spring loaded with fusible links. All testing was functionally	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 067	Continued From page 8 Review of the fire alarm testing and maintenance records on 07/08/14 from 1:20 PM to 2:15 PM revealed the lack of the four year fire damper testing as required by NFPA 90A-1999, Section 3-4.7. At the time of the review, the Facility Maintenance Manager acknowledged the lack of documentation for these fire damper tests.	K 067	correct. Testing was conducted by a licensed HVC vendor. Identification of Others: An audit of facility fire dampers Was completed and identifying Issues were corrected. System Measures: Preventative maintenance audits Will be completed on fire dampers To ensure compliance with standards. Monitoring: Maintance Director and/or designee will monitor for compliance. Data obtained by the way of preventative maintenance audits will be analyzed fro patterns and trends reported monthly to the QAPI committee. The QAPI committee will evaluate based on trends identified and interventions as needed to ensure continued compliance monthly x3.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the means of egress was free of all obstructions or impediments. The findings were:	K 072	K072 Corrective Action: 7 inches of the handrail will be removed	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 072	Continued From page 9 Observation of the Therapy Gym doors on 07/09/14 at 9:05 AM revealed that when the doors where fully opened, they projected more than 7 inches into the required width of the corridor. At the time of the observation, the Facility Maintenance Manager acknowledged the doors projection into the corridor. REFERENCE NFPA 101 Life Safety Code, 2000 Edition 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)	K 072	from each side of the therapy gym room doors, by maintenance staff. Identification of Others: An audit of facility doors was completed and identified issues will be repaired on or before 8/24/14. System/Measures: An audit of therapy room entrance was completed and all identified issues will be corrected on or before 8/24/14. Monitoring: Maintenance Director/designee will Monitor for compliance. Data obtained by the 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.	
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 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	K 074		8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 074	Continued From page 10 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 review the facility maintenance records and staff interview, the facility failed to provide documentation for the maintenance of fire retardant coatings in compliance with the requirements of NFPA 101. The findings were: Review of facility maintenance records on 07/08/14 from 1:20 PM to 2:15 PM revealed the absence of documentation on the maintenance of fire-retardant coatings. Interview with the Facility Maintenance Manager at the time of the review acknowledged the lack of documentation for maintenance of fire-retardants. REFERENCE NFPA 101 Life Safety Code, 2000 Edition 19.7.5 Furnishings, Bedding, and Decorations. 19.7.5.1 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.) 10.3.1 * Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Method of Fire Tests for Flame	K 074	K074 Corrective Action: All draperies,curtains,and loosely hanging fabrics and films serving as furnishings or decorations have been treated with Fire Block Fire Retardant. As new items are purchased and Sued in the facility Fire block Fire retardant will be applied per the policy and procedure. Identification of Others; An audit of the facility was completed and all flammable items have been sprayed with Fire Retardant Fire Block. System/Measures: Annual and as needed preventative maintenance audits will be completed of facility decorations 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	

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 074	Continued From page 11 Propagation of Textiles and Films.	K 074	evaluate the effectiveness of the plan based on trends identified and implemented additional interventions as needed. ensure compliance monthly X3.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an adequate medical gas storage area per NFPA 99. The findings were: Observation of the Oxygen Storage Room on 07/09/14 at 9:18 AM revealed primary electrical equipment located inside the Oxygen Storage Room. REFERENCE NFPA 99, 1999 Edition 8.3.1.11.2(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft. (6.1 m) of outside storage locations.	K 076	K076 Corrective Action: The oxygen storage area will be relocated. We are accepting bids for the construction of a small oxygen storage building. Plans will be submitted to HLS for review. Identification of Others: An audit of the facilities oxygen storage was completed. Issues identified are being addressed. Bids are presently being accepted for a new structure.	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 076	Continued From page 12	K 076	Systems/Measures: The division director of facility engineering and the director of maintenance will work with Department of Health to meet all of state guidelines. Monitoring: The director of facility engineering And the director of Maintenance will Over see this process.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: a. Based on observation and staff interview, the facility failed to provide doors that were opened readily from the egress side. The findings were: Observation of the Maintenance Office in the 200 wing on 07/09/14 at 10:50 AM revealed a combination padlock securing the folding partition on the corridor side between the room and the exit access corridor. Observation revealed a storage room accessible from the Maintenance Office. The locking of the folding partition could trap an occupant in the storage room who may not be directly observable. Interview with the Facility Maintenance Manager at the time of the review acknowledged the possibility of trapping an occupant behind the locked folding wall. REFERENCE NFPA 101 Life Safety Code, 2000 Edition	K 130	K130 Corrective Action: The identified according door on the maintenance directors office, the doorknob on the activity room restroom, and the doorknob on the Alzheimer's dining room door will be replaced with new hardware, that is code compliant. Identification of others: An audit of facility doors and hardware was completed and identified hardware will be replaced. System/Measures: Annual and as needed preventative maintenance audits will be completed of facility doors to ensure compliance with	8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 130	Continued From page 13 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. b. Based on observation and staff interview, the facility failed to provide door hardware that were operable with only one action and without tight pinching to operate. The findings were: Observation of the Activities Toilet Room on 07/09/14 at 9:35 AM revealed a thumb-turn lock on the door knob. The action of the knob did not release the lock in one release action and the thumb-turn lock required tight pinching to release. Interview with the Facility Maintenance Manager at the time of the review acknowledged the door hardware. REFERENCE NFPA 101 Life Safety Code, 2000 Edition 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This requirement is permitted to be satisfied by the use of conventional types of hardware, whereby the door is released by turning a lever, knob, or handle or by pushing against a panic bar, but not by unfamiliar	K 130	standard is met. Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the 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 as needed to ensure continued compliance monthly X3.	

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1651 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
K 130	Continued From page 14 methods of operation such as a blow to break glass. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of the wrist to operate. c. Based on observation and staff interview, the facility failed to provide approved special locking arrangements. The findings were: Observation of the Alzheimer Dining Room on 07/09/14 at 10:45 AM revealed two doors into the room; one accessed from the secured unit corridor and one accessed from the non-secured corridor. The door accessing the secured unit was locked on the corridor side by a key but keyed locking was not observed on the dining room side of the door. The door accessing the non-secured unit could be locked by a key on the door knob on both the dining room side and on the non-secured side of the door at the corridor. Interview with the Facility Maintenance Manager at the time of the review acknowledged the dining room was utilized by residents from both the secured unit and the non-secured units. The Facility Maintenance Manager acknowledged she was unaware that only areas where the clinical needs of all the patients could include specialized security measures. The Facility Maintenance Manager also acknowledged she did not have a key to unlock the door from the dining room into the secured unit. REFERENCE NFPA 101 Life Safety Code, 2000 Edition 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130		

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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 _____	07/09/2014

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
K 130	Continued From page 16 Exception No.1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No.2: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No.3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 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 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. 19.1.1.1.5 It shall be recognized that, in buildings housing certain types of patients or having detention rooms or a security section, it might be necessary to lock doors and bar windows to confine and protect building inhabitants. In such instances, the authority having jurisdiction shall make appropriate modifications to those sections of this Code that would otherwise require means of egress to be kept unlocked.	K 130		
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.	K 141		8/24/14

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 _____	07/09/2014

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
K 141	Continued From page 16 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an adequate medical gas storage signs per NFPA 99. The findings were: Observation of the Oxygen Storage Room on 07/09/14 at 9:18 AM revealed signage posted on the outside of the door that did not include the minimum wording per NFPA 99. REFERENCE NFPA 99, 1999 Edition 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 1.5 m (5 ft), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 141	K141 Corrective Action: A sign with the wording "Caution Oxidizing Gas(es) Stored within the No Smoking has been ordered and will be posted on oxygen room door by Maintenance Staff. Identification of Others: An audit of oxygen signage was completed and appropriate signage has been ordered and will be posted on oxygen door. Systems/Measures: Annual and as needed preventative maintenance audits will be completed of facility oxygen room signage to ensure compliance with standard. Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the way 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 compliance monthly x3.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.	K 144		8/24/14

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 144	Continued From page 17 This STANDARD is not met as evidenced by: Based on review of the facility maintenance records and staff interview, the facility failed to provide documentation for the monthly generator load test in compliance with the requirements of NFPA 99. The findings were: Review of facility maintenance records on 07/08/14 from 1:20 PM to 2:15PM revealed the absence of documentation on the generator test for the month of December 2013. Per NFPA 99-1999, Section 3-4.4.1.1, Generator sets shall be tested twelve times a year with testing intervals not less than 20 days or exceeding 40 days. Interview with the Facility Maintenance Manager at the time of the review acknowledged the lack of documentation for this monthly generator test.	K 144	K144 Corrective Action: Monthly Audits have been done on the generator, with the expectation of December 2013. Director of maintance will ensure tests are done monthly by reviewing all results. Identification of Others: This issue has been identified and monthly audits will be performed to avoid further problems. Systems/Measures: Monthly audits will be completed on the generator testing to ensure compliance with the standards. monitoring: Maintenance Director and/or Designee will monitor for compliance. Data obtained by audits will be analyzed for patterns and trends reported monthly to facility QAPI committee. The QAPI committee will evaluate the effectiveness of this plan by its trends identified and implement additional interventions as needed to	

PRINTED: 09/24/2014
FORM APPROVED
OMB NO. 0938-0391

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	07/09/2014

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
K 144	Continued From page 18	K 144	ensure continued compliance monthly x3.	