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

PRINTED: 08/31/2015
FORM APPROVED
OMB NO. 0938-0391

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	08/19/2015

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 86.	K 000		
K 018 SS=E	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: 1. Secure Unit door when closed would drag and hang up on floor, preventing door from closing. Bottom of door was sanded and the door was 2. Room 504 door would not latch, door in 504 has been adjusted and now closes. 3. Admissions Office door would not latch into door frame. Adjusted door hinges, door now closes. 4. Room 406 door not latching. Door has been adjusted and is now closing.	

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

Steve Olson | Administrator | 9/11/15

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 via Phone Call with Administrator Bruce Allison 9/16/15 @ 4:16pm

34354

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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 provide a suitable means of keeping the doors accessing the egress corridors closed in 4 of 9 smoke compartments. The findings were: 1. Observation on 08/19/15 at 10:25 AM of the secured unit dining room door revealed when the door was closed, it would drag and hang up on the floor preventing it from fully closing. At the time of the observation the Facility Maintenance Manager acknowledged the door would not fully close. 2. Observation on 08/19/15 at 10:50 AM of room #504 revealed when the door was fully closed it would not latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into its frame. 3. Observation on 08/19/15 at 11:05 AM of the admissions office revealed when the door was fully closed it would not latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into its frame. 4. Observation on 08/19/15 at 11:15 of room #406 revealed when the door was fully closed it would not latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into its frame. Ref:	K 018	Identification of Others: An audit of all doors will be conducted monthly to ensure all doors close properly. Systems/Measures: Annual as well as needed preventative maintenance audits will be completed of the facility doors 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 month X3	10/2/15

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K 018	Continued From page 2 2000 NFPA 101 Section 19.3.6.3.2	K 018		
K 027 SS=D	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 observation and staff interview, the facility failed to ensure 1 of 5 cross-corridor smoke barrier doors were not smoke resistant. The findings were: Observation on 08/19/15 at 10:32 AM revealed the cross corridor smoke barrier doors located adjacent to activity office would not fully close when activated. At the time of the observation the Facility Maintenance Manager acknowledged the doors would not fully close. Ref: 2000 NFPA 101 Section 19.3.7.5	K 027	K-027 Corrective Action: Smoke barrier doors located adjacent to activity room have been adjusted and the doors now close. Identification of Others: An audit of all doors will be conducted monthly to ensure all doors close properly. Systems/Measures: Annual as well as needed preventative maintenance audits will be completed of the facility doors 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.	
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	K 029	QAPI committee will evaluate Based on trends identified and interventions as needed to ensure continued compliance month X3	

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K 029	Continued From page 3 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 protected from the corridor with self-closing doors in 1 of 9 smoke compartments. The findings were: Observation of the secured unit storage room on 08/19/15 at 10:20 AM revealed the door was provided with a self-closing device, but when activated would not fully close and latch the door into its frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not fully close and latch. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	K029 Corrective Action: Secure unit storage door was adjusted to allow closure. Also removed items hanging on the back of the door, this also allowed the door to close. Identification of Others: An audit of all doors will be conducted monthly to ensure all doors close properly. Systems/Measures: Annual as well as needed preventative maintenance audits will be completed of the facility doors 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 month X3	10/2/15
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	K 038		

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 1 of 9 smoke compartments. The findings were: 1. Observation on 08/19/15 from 9:10 AM to 10:00 AM revealed door locks that required special knowledge or effort for operation from the egress side. When locked doors to room #207 and the rehab hall bathroom required more than one releasing operation. At the time of the observations the Facility Maintenance Manager acknowledged the locks on the doors. 2. Observation on 08/19/15 at 11:05 AM revealed the deer lane egress door required more than 15lb of force to activate the releasing hardware. At the time of the observation the facility maintenance manager acknowledged the door hardware required more than 15lbf to activate the releasing process. Ref: 2000 NFPA 101, Sections 19.2.2.2.1, 7.2.1.4.5, 7.2.1.6.1, 7.2.1.5.1, and 7.2.1.5.4	K 038	K038 Corrective Action: 1. Room 207 and the Rock Creek Public Bathroom door knobs have been replaced with single action locks. Locks have been ordered for the Activity Room door and SDC office. 2. Lubricated and cleaned releasing hardware on the Deer Lane egress door. The door now closes properly. Identification of Others: An audit of all doors will be conducted monthly to ensure all doors close properly. Systems/Measures: Annual as well as needed preventative maintenance audits will be completed of the facility doors to ensure compliance with standard.	
K 062 SS=D	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 observation and staff interview, the	K 062		

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 1 of 9 smoke compartments. The findings were: 1. Observation on 08/19/15 from 9:10 AM to 10:00 AM revealed door locks that required special knowledge or effort for operation from the egress side. When locked doors to room #207 and the rehab hall bathroom required more than one releasing operation. At the time of the observations the Facility Maintenance Manager acknowledged the locks on the doors. 2. Observation on 08/19/15 at 11:05 AM revealed the deer lane egress door required more than 15lb of force to activate the releasing hardware. At the time of the observation the facility maintenance manager acknowledged the door hardware required more than 15lbf to activate the releasing process. Ref: 2000 NFPA 101, Sections 19.2.2.2.1, 7.2.1.4.5, 7.2.1.6.1, 7.2.1.5.1, and 7.2.1.5.4	K 038	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 month X3	10/2/15
K 062 SS=D	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 observation and staff interview, the	K 062	K062 Corrective Action: Metal sign has been ordered for main boiler room fire system riser. It was ordered from Simplex Grinnel and is scheduled to arrive here on 9/14/15.	

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K 062	Continued From page 5 facility failed to ensure that the required design information was posted on the fire sprinkler riser. The findings were: Observation on 08/19/15 at 11:20 AM of the sprinkler riser revealed no hydraulic design information was provided at the riser. At the time of the observation the Facility Maintenance Manager acknowledged the design information was not posted. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 10-5	K 062	Identification of Others: An audit of the boiler room will be conducted monthly by the Director of Maintenance to ensure all required signage is in place. Systems/Measures: Annual and as needed preventative maintenance audits will be completed of the boiler room to ensure compliance with standards are met.	
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 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	K 074	Monitoring: Director of Maintenance/ designee will monitor for compliance. Data obtained by the way of prevention maintenance audits will be analyzed for patterns and trends reported monthly to the QAPI committee. QAPI committee will evaluate based on trends identified and intervention as needed to ensure compliance month X3.	10/2/15

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K 074	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide documentation for the maintenance of fire retardant coatings in compliance with the requirements of NFPA 101 in 1 of 9 smoke compartments. The findings were: Observation on 08/19/15 at 9:50 AM and 9:55 AM of rooms #118 and #119 revealed draperies in both rooms had not been treated with fire retardant spray. Interview with the Facility Maintenance Manager at the time of the observations confirmed the draperies in both rooms had not been treated. Ref: 2000 NFPA 101 Sections, 19.7.5.1 and 10.3.1	K 074	K074 Corrective Action: New window covering for rooms 118 and 119 have been ordered. Current window coverings have been treated with fire retardant and have been dated. Identification of Others: An audit of the facility will be conducted monthly to ensure compliance that all fabric and wall decorations are treated with a fire retardant spray. Systems/Measures: Preventative Maintenance audits will be completed of the facility's décor to ensure compliance with the standards. 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 month X3.	10/2/15