| 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<br>B. WING _____ | 04/27/2011 |

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

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| K 000 | INITIAL COMMENTS<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this 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 (NFPA).<br><br>The facility was a fully sprinkled single story building with a basement of Type V (111) construction with plan approval in 1962 and 1988. The building was equipped with a supervised automatic dry sprinkler system and a zoned fire alarm system. The facility had a capacity of 128 certified Medicare and Medicaid beds with a census of 87 residents. | K 000 | Preparation and/or execution of the response and plan of correction does not constitute admission or agreement by the provider of the Truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. | |
| K 025<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure 1 of 8 smoke barrier walls were smoke resistant. The findings were: | K 025 | **K-025 – Plan of Correction**<br><br>Corrective Action: The identified smoke barrier wall cable penetration has been repair and sealed.<br><br>Identification of Others: An audit of the facilities smoke barrier walls was completed and all identified issues were repaired.<br><br>Systems/Measures: Annual and as needed preventative maintenance audits will be completed on all smoke barrier walls to ensure compliance with standard. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaw — TITLE: administrator — (X6) DATE: 05/13/11

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.

RECEIVED
Wyoming Dept of Health
MAY 19 2011
Office of Healthcare Licensing and Surveys

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| K 025 | Continued From page 1<br>Observation of the chapel hall smoke barrier wall on 4/27/11 at 3:39 PM showed there was one unsealed cable penetration. The hole around the coaxial cable was 1 inch in diameter. At the time of observation the maintenance director reported the barrier walls were inspected on a quarterly basis. He stated he did not know why the hole had not been repaired. | 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 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 x 3. | 06/03/11 |
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>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:<br><br>Observation on 4/27/11 at 9:21 AM showed the floor buffer, 10 buffing pads, and buffing chemicals were stored in the tub room near resident room #208. Further review showed the corridor door had a 3-inch gap between the bottom of the door and the floor. The door was not equipped with an automatic closing device. At | K 029 | **K- 029 – Plan of Correction**<br><br>Corrective Action: The identified buffing pads and chemicals have been removed and stored in a proper storage room. The identified 3-inch gap between the bottom of the door has been repaired and the gap is now less than 1 inch. An automatic closing device has been installed.<br><br>Identification of Others: An audit of the facilities storage rooms was completed and all identified issues were repaired.<br><br>Systems/Measures: Monthly preventative maintenance audits will be completed for facility storage areas to ensure compliance with standards. | |

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| K 029 | Continued From page 2<br>the time of observation the maintenance director reported he was not aware of the separation requirement for storage locations. | K 029 | 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 will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly x 3. | 06/03/11 |
| K 062 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure sprinklers were unobstructed in 1 of 9 smoke compartments. The findings were:<br><br>Observation of the Alzheimer's clean utility room on 4/27/11 at 2 PM showed a sprinkler head was obstructed by the ceiling- mounted light. The light was located 6 inches away and from 2 inches below the bottom of the sprinkler deflector. At the time of observation the maintenance director confirmed the sprinkler was obstructed. He also reported the system was inspected annually by an outside contractor, and the last report did not indicate any heads were obstructed. | K 062 | K-062 – Plan of Correction<br><br>Corrective Action: The identified obstruction to the sprinkler head has been removed.<br><br>Identification of Others: An audit of the facilities smoke compartments was completed and all identified issues were repaired.<br><br>Systems/Measures: Annual and as needed preventative maintenance audits will be completed on facility smoke compartments to ensure compliance with standard.<br><br>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 | |
| K 144 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. | K 144 | | |

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| K 144 | Continued From page 3<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure a manual emergency stop button was provided on 1 of 1 newly installed emergency generator. The findings were:<br><br>Observation of the west generator on 4/27/11 at 4:01 PM showed it was not equipped with a manual remote stop button outside of the room where the prime mover is located. At the time of observation the maintenance director stated he was unaware of this requirement.<br><br>Reference:<br>NFPA 110 Standard for Emergency and Standby power systems, 1999 edition:<br>3-5.5.6 All Level 1 and Level 2 installations shall have a remote manual stop station of a type similar to the break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. | K 144 | reported monthly to the facility 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.<br>K-144 – Plan of Correction<br><br>Corrective Action: The west generator was equipped with a manual remote stop button located outside of the room where the generator is located.<br><br>Identification of Others: This issue has been identified and only affects this generator.<br><br>Systems/Measures: Weekly preventative maintenance inspections will be completed on generator to ensure compliance with standard.<br><br>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. | 06/03/11<br><br>06/03/11 |