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

PRINTED: 10/04/2016
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
	535028	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/21/2016

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 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain locking mechanism on exterior exit door. The finding were: Observation on 9/21/12016 8:40 PM revealed the exterior exit at the end of Hall 400 required that a force in excess of 15 lbf be continuously applied to move the locking mechanism and open the door. Interview with the Facility Maintenance Manager at the time of the observation acknowledge that the door exceeded the 15 lbf to open. Ref: 2000 NFPA 101, 19.2.2.2.1, 7.2.1.6 (6)	K 021	**K 021 LIFE SAFETY CODE STANDARDS** Facility is to maintain locking mechanism on exterior doors that does not exceed 15 lbs. of continuously pressure to open. **Corrective Action:** The exit door at the end of the 400 hall push bar latching system was lubricated adjusted and the track has been cleaned out and now it does not exceed 15lbs. continuously applied to open. **ID of Others:** An audit of all self closing/locking Doors throughout the facility does not exceed 15 lbs. of continuously pressure to open was completed by NHA and Maintenance Director. Any areas found were cleaned and repaired. **Systemic Changes:** The NHA/Designee will educate the Maintenance Director regarding self closing/locking doors not exceed 15 lbs. of continuously pressure to open. The Maintenance Director /designee will complete daily audits of self closing/locking doors. Audits will also identify any self closing/locking door that exceeds 15 lbs. of continuously pressure to open. The MD/Designee will educate the maintenance	11/2/16
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/16/16

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
WY Dept of Health
OCT 26 2016
Healthcare Licensing and Surveys

Accepted plan of correction via phone call with administrator Derek Holbrook on 10/07/2016

36540

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K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain locking mechanism on exterior exit door. The finding were: Observation on 9/21/12016 8:40 PM revealed the exterior exit at the end of Hall 400 required that a force in excess of 15 lbf be continuously applied to move the locking mechanism and open the door. Interview with the Facility Maintenance Manager at the time of the observation acknowledge that the door exceeded the 15 lbf to open. Ref: 2000 NFPA 101, 19.2.2.2.1, 7.2.1.8 (6)	K 021	staff regarding the self closing/locking doors to not exceed 15 lbs. of continuously pressure to open. A weekly audit tool will be completed by the NHA/designee to ensure there are no self closing/locking doors exceeding 15 lbs. of continuously pressure to open. Monitoring: Results of all self closing/locking Doors throughout the facility does not exceed 15 lbs. of continuously pressure to open audits will be reported to the QAPI Committee monthly by the Maintenance Director or designee for tracking and trending. The QAPI Committee evaluate the trends identified and implement additional Interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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

Administrator 10/26/16

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.

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K 029	Continued From page 1 One hour fire rated construction (with o 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 free from hazards. The findings were: Observation on 09/28/16 at 9:45 AM of the electrical room accessed via Rock Creek Courtyard revealed that the space was being used for storage of combustible materials. Further observation revealed service clearance was not available in front of the electrical gear. Interview at the observation the Facility Maintenance Manager acknowledged the combustible material restricting access to the electrical gear. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	**K 029 LIFE SAFETY CODE STANDARDS** The Facility is committed to ensure hazardous areas free from hazards. **Corrective Action:** The combustible material and housekeeping equipment was removed from the area the same day. **ID of Others:** An audit to ensure all rooms with electrical gear has access and do not contain combustible materials. **Systemic Changes:** The NHA/Designee will educate the Maintenance Director regarding that all rooms with electrical gear have access and do not contain combustible materials. The Maintenance Director /designee will complete daily audits of all rooms with electrical gear has access and do not contain combustible materials. A weekly audit tool will be completed by the NHA/designee to ensure that all rooms with electrical gear have access and do not contain combustible materials. **Monitoring:** Results of all rooms with electrical gear have access and do not contain combustible materials audits will be	11/2/16
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 047		11/2/16

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K 029	Continued From page 1 One hour fire rated construction (with o 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 free from hazards. The findings were: Observation on 09/28/16 at 9:45 AM of the electrical room accessed via Rock Creek Courtyard revealed that the space was being used for storage of combustible materials. Further observation revealed service clearance was not available in front of the electrical gear. Interview at the observation the Facility Maintenance Manager acknowledged the combustible material restricting access to the electrical gear. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	reported to the QAPI Committee monthly by the Maintenance Director or designee for tracking and trending. The QAPI Committee evaluate the trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	11/2/16 AD
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 047	**K 047 LIFE SAFETY CODE STANDARDS** The Facility is committed to provide exit signs in accordance with NFPA 101. **Corrective Action:** The exterior door on Rock Creek leading to the court yard that has "Not an Exit" has been ordered and will be replaced as soon as it comes in. The Exit sign from the 200 Hall looking towards the SCU has been lowered to make it visible.	11/2/16 AD

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K 047	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed provide exit signs in accordance with NFPA 101. The findings were: 1. Observation on 9/21/16 at 9:34 AM revealed the exterior exit door in the Rock Creek Courtyard was labeled as "Not and Exit" vs "NO EXIT". Further observation revealed this was typical throughout the survey for similar doors. Interview with Facility Maintenance Manager acknowledged the exits was marked with "Not and Exit signs." 2. Observation on 09/21/2016 at 10:17 AM of the 200 Hall looking north towards SCU revealed that the exit sign was mounted too high and not visible above the cross-corridor door. Interview at the time of the observation with the Facility Maintenance Manager acknowledged the exit sign was too high and not visible. Ref: 2000 NFPA 101, Sections 19.2.10.1, 7.10.8.8 and 7.10.1.2	K 047	ID of Others: An audit to ensure all "No Exit" are marked proper and all Exits signs are visible was conducted by the NHA and Maintenance Director if any was found they were repaired or ordered and will be installed upon arrival. **Systemic Changes:** The NHA/Designee will educate the Maintenance Director that ensures all "No Exit" are marked proper and all Exits signs are visible. The Maintenance Director /designee will complete weekly audits to ensure all "No Exit" are marked properly and all Exits signs are visible. **Monitoring:** Results of all "No Exit" are marked and all exit signs are visible audits will be reported to the QAPI Committee monthly by the Maintenance Director or designee for tracking and trending. The QAPI Committee evaluate the trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	11/2/16
K 107 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1 This STANDARD is not met as evidenced by: Based on observation review and staff interview, the facility failed to meet the requirement that fire alarm systems has been installed in accordance with NFPA 72. The findings were:	K 107		11/2/16

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K 107 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1 This STANDARD is not met as evidenced by: Based on observation review and staff interview, the facility failed to meet the requirement that fire alarm systems has been installed in accordance with NFPA 72. The findings were:	K 107	**ID of Others:** An audit was conducted by the NHA and Maintenance Director identifying all Fire pull stations that are higher than 58 inches from the floor. All that were identified and put on a work order to be ordered and repaired.	

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K 107	Continued From page 3 Observation on 09/21/2016 at 8:50 AM revealed the pull stations were at 58 inches above the floor throughout the facility. Interview with the facility Maintenance Manager at the time of observation acknowledged the pull stations were at 58 inches above the floor. Ref: 2000 NFPA 101, Sections 9.6.1.4 1999 NFPA 72, Section 2-8.1	K 107	**Systemic Changes:** The NHA/Designee will educate the Maintenance Director that all Fire pull stations that are higher than 58 inches from the floor. The Maintenance Director /designee will work with electrician contractors to replace any fire pull stations higher than 58 inches from the floor.	11/2/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical wiring and equipment in accordence with NFPA 70. The findings were; Observations on 09/21/2016 at 8:47 AM revealed in rooms 412 and 413 medical equipment (concentrators) were connected to power taps. This observation was consistent throughout the facility. Further observation revealed the power taps were not UL 1363A approved. Interview at the time of the observation with the Facility Maintenance Manager acknowledged the medical equipment connected to the power taps. Ref: Ref: S&C: 14-46-LSC September 26, 2014	K 147	**Monitoring:** The QAPI Committee will review any trends identified monthly until substantial compliance is achieved and then bi-monthly thereafter. **K 147 LIFE SAFETY CODE STANDARDS:** The facility is also committed to have medical equipment connected to power strips that are rated at UL 1363A approved. **Corrective Action:** All medical equipment that was connected to power strips not rated UL 1363A were unplugged and plugged directly into power outlet in the wall.	11/2/16

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K 107	Continued From page 3 Observation on 09/21/2016 at 8:50 AM revealed the pull stations were at 58 inches above the floor throughout the facility. Interview with the facility Maintenance Manager at the time of observation acknowledged the pull stations were at 58 inches above the floor. Ref: 2000 NFPA 101, Sections 9.6.1.4 1999 NFPA 72, Section 2-8.1	K 107	ID of Others: An audit will be conducted by the NHA and Maintenance Director on or before the date of compliance to identify all power strips not rated UL1363A and a work order will be completed for the repairs. Systemic Changes: The NHA/Designee will educate the Maintenance Director that all medical equipment has to be connected to power strips that are rated at UL 1363A approved. The Maintenance Director /designee will complete weekly audits to ensure all medical equipment is connected to UL 1363A power strips or directly plugged into wall outlet. A monthly audit tool will be completed by the NHA/designee to ensure that all medical equipment is connected to UL 1363A power strips or directly to the wall outlet. Monitoring: The QAPI Committee will review any trends identified monthly until substantial compliance is achieved and then bi-monthly thereafter.	11/2/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code, 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical wiring and equipment in accordance with NFPA 70. The findings were: Observations on 09/21/2016 at 8:47 AM revealed in rooms 412 and 413 medical equipment (concentrator's) were connected to power taps. This observation was consistent throughout the facility. Further observation revealed the power taps were not UL 1363A approved. Interview at the time of the observation with the Facility Maintenance Manager acknowledged the medical equipment connected to the power taps. Ref: Ref: S&C: 14-46-LSC September 26, 2014	K 147		