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 _____	12/11/2008

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 sprinklered single story building of Type V(III) construction built in 1962 and 1988. The building was equipped with a supervised automatic dry sprinkler system and fire alarm system.	K 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the Truth of the ~~facts alleged or~~ conclusions set forth in 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.	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a smoke partition was maintained as required in 2 of 8 smoke compartments. The findings were: Observation on 12/10/08 at 1:48 PM revealed three unsealed penetrations of the ceiling tile in the following locations: 1) a 2x2 inch hole was located directly over the employee time clock. 2) a 1x1 inch hole was located over the east nurses station directly next to a plastic phone line conduit. 3) a 1x1 inch hole was located in the ceiling next to the sprinkler head in the shower room at the east nurses station. Interview with the facility's maintenance manager on 12/10/08 at 2 PM verified that the three holes should be	K 012	**TAG K 012** The 2 x 2 inch hole directly over the employee time clock has been repaired. The 1 x 1 inch hole over the East Nurses' Station has been repaired. The 1 x 1 inch hole in the ceiling next to the sprinkler head in the shower room at the East Nurses' Station has been repaired. Residents in the area of the employee time clock, the area around the East Nurses' Station and in the shower room at the East Nurses' Station may be affected. An audit of all residents' rooms and common areas in the building has been completed by the Director of Maintenance to identify any smoke partition penetrations. Maintenance Director and/or designee will monitor for compliance. Results will be reported to the Safety Committee.	1/7/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Conaway — TITLE: administrator — (X6) DATE: 01/06/09

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
JAN 07 2009

Plan of Correction Accepted w/ Date Corrected, Nikki, 1/12/09

Office of Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535026	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/11/2008

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 012	Continued From page 1 caulked.	K 012		
K 029 SS=E	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 a hazardous area was separated from patient areas in 1 of 8 smoke compartments. The findings were: Observation on 12/10/08 at 9:48 AM revealed there lacked a self-closure device (SCD) on the closet door opposite the tub room that was located next to the receptionist's desk. The room contained more than nineteen of paper files, twenty paper binders and ten reams of paper. The room dimensions were 5 ft x 4 ft. Interview with the facility's maintenance manager at 2:22 PM confirmed he was aware that the large volume of paper stored in the small room constituted a potential hazard.	K 029	**TAG K 029** The identified closet door located next to the receptionist's desk has had a self-closure device installed. Residents in the identified area may be affected by this deficient practice. An audit of all storage areas has been completed by the Maintenance Director and/or designee to ensure compliance. Any identified areas with a potential hazard will be corrected. The Maintenance Director and/or designee will monitor for compliance. Results will be reported to the Safety Committee.	1/7/09
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		

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 _____	12/11/2008

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 050	Continued From page 2 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure a staged fire drill was conducted during each shift of each quarter. The findings were: A fire drill was not conducted during the night shift of September 2007. Interview with the facility maintenance manager on 12/10/08 at 2 PM revealed he was hired during the third quarter of 2007 and was not aware that a fire drill was supposed to be conducted on the night shift.	K 050	**TAG K 050** The facility will ensure that fire drills are completed each shift of of each quarter. Residents in the facility may be affected by this deficient practice. The Maintenance Director and/or designee will complete fire drills for each shift every 30 days for the first 90 days beginning 1/1/09 and quarterly thereafter. The Maintenance Director and/ or Administrator will monitor to ensure compliance. Results will be reported to the Safety Committee and the Quality Assurance Committee.	1/7/09
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 facility failed to ensure the fire sprinkler system was properly maintained. The findings were: Observation on 12/10/08 between at 11:22 AM	K 062	**TAG K 062** The half inch gaps between the escutcheon and the ceiling in the bathroom of room 510, the physical/ occupational therapy room and resident room 410 have been closed/repaired. The lint and dust on the identified fire sprinkler has been removed. Residents in these identified areas have the potential to be affected. An audit of all resident rooms has been completed by the Maintenance Director and/or designee to identify any potential problems with the fire sprinkler system.	1/7/09

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 _____	12/11/2008

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 062	Continued From page 3 and 1:13 PM revealed a half inch gap between the escutcheon and the ceiling in the following locations: 1. The bathroom of resident room #510 2. The physical/occupational therapy room. 3. Resident room #410. In addition, the sprinkler head in the hallway to the laundry room was coated with lint and dust.	K 062	The Maintenance Director and/ or designee will monitor for compliance. Results will be reported to the Safety Committee and the Quality Assurance Committee.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents were protected from exposed electrical wires or that temporary flexible wiring was not used in place of fixed permanent electrical wiring in 1 of 8 smoke compartments. The findings were: 1. Observation on 12/10/08 at 1:42 PM revealed an electrical light switch on the wall next to the exit door in the Medicare hall that had separated from the wall, exposing live electrical wires. In addition, the call light in resident room #508 had also separated from the wall, exposing live electrical wires. 2. Observation on 12/10/08 at 2:15 PM revealed a surge protector was plugged into another surge protector in the storeroom in the special care unit. Twelve electric razors were plugged into both surge protectors. Interview with the facility maintenance manager at 2:15 PM confirmed the above.	K 147	**TAG K 147** The facility will ensure that residents are protected from exposed electrical wires. The identified electrical light switch and the call light in resident room 508 have been repaired. The identified surge protector has been removed. Residents in the identified areas have the potential to be affected. An audit of all resident rooms and common areas to identify potential hazards will be completed by the Maintenance Director and/or Designee. The Staff Development Coordinator Conducted an in-service on 12/31/08 regarding the regulations on the use of surge protectors in the facility. Maintenance Director and/or designee will monitor for compliance. Results will be reported to the Safety Committee and the Quality Assurance Committee.	1/7/09