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OCT 12 2018

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

Healthcare Licensing and Surveys

PRINTED: 09/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 635028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2018
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 09/12/2018. 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 2012 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(111) construction built in 1982 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 84.	K 000			
K 321 88=D	Hazardous Areas - Enclosure CFR(42): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321	K 321 Corrective Action: Penetration fixed by sealing with proper fire retardant mixture on 9/12/2018 to NFPA specifications Identification of Others: All rooms and spaces where wires or pipes penetrate through the walls have the potential to be affected. Systemic Changes: Maintenance director or designee will complete a facility wide sweep to ensure all penetrations are sealed and will audit spaces bi-weekly for 3 months to ensure that no penetrations exist.	10/16/2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DATE

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 required to continued program participation.

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: 8144821

Facility ID: WY0023

If continuation sheet Page 1 of 4

POC approved with Administrator Dennis Tofano on 10/15/2018 at 1:10pm
 Alberto Schanemann via phone call.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535026	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2018
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous areas could result in injury or death in the event of a fire in the area. The deficiency affected one (1) of six (6) smoke compartments. The findings were: Observation on 09/12/18 at 12:30 PM revealed that the storage room labeled "Century Tub" had unprotected plumbing penetrations. Storage areas protected with an automatic sprinkler system shall be separated from other spaces by smoke partitions. Interview with the maintenance director at the time of the observation acknowledged the deficiency, and indicated that he was aware of the requirement, but revealed that he was unaware of the deficiency before the survey. Interview with the administrator at the time of exit acknowledged the deficiency.	K 321	Ongoing Monitoring: Audits will be presented by Maintenance Director to QAPI monthly for compliance verification. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2018
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1861 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 321	Continued From page 2	K 321			
K 324 SS=D	Reference: 2012 NFPA 101 Section 19.3.2.1.2, 8.4.4.1 Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 98 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.6, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect cooking facilities could	K 324	K324 Corrective Action: Life Safety surveyor instructed maintenance director on regulation for fire shutter window in dining area on 9/12/2018. Identification of Others: All residents in dining area during meal time has the potential to be affected. Systemic Changes: Contractor notified 10/1/2018 regarding options to meet NFPA specifications for the serving window. Quotes and work order forthcoming by 10/16/2018. Ongoing Monitoring: The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for three months then reassess the need for continued monitoring based on compliance.	10/16/2018	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 626028	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2018
NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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 324	Continued From page 3 result in injury or death in the event of a fire in the area. The deficiency affected one (1) of six (6) smoke compartments. The findings were: Observation on 08/12/18 at 1:15 PM revealed a serving line between the kitchen and dining room which had swinging wooden doors. The dining room is directly open to the corridor. Commercial cooking facilities that serve more than 30 persons shall not be permitted to be open to the corridor. Interview with the maintenance director at the time of the observation acknowledged the deficiency, but indicated he was unaware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 Section 19.3.3.2.5.6	K 324			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 538026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2018
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NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1851 BIG HORN AVE SHERIDAN, WY 82801
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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 09/12/2018.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(a): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCs at 5403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop policies and procedures for the use of volunteers in an emergency.	E 024 E024 CORRECTIVE ACTION Policy and procedures are in place on 10/12/2018 for volunteer use in an emergency situation IDENTIFICATION OF OTHERS No other policy and procedures were affected SYSTEMIC CHANGE Maintenance Director or designee will check the Emergency Preparedness manual monthly for applicable updates for 3 months and report findings monthly to QAPI. MONITORING Maintenance Director or designee will check the Emergency Preparedness manual monthly for applicable updates for 3 months and report findings monthly to QAPI.	10/16/2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

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 60 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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E 024	Continued From page 1 The findings were: Document review of the Emergency Preparedness Plan on 09/12/18 at 1:55 PM revealed that policies or procedures for use of volunteers were not available. Interview with the facility administrator acknowledged that they were missing documentation, but he believed that policies and procedures had been developed for use of volunteers.	E 024			
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the	E 036	E036 CORRECTIVE ACTION Policy and Procedure has been put in place for the implementation of testing and training on 10/12/18. Table top training done within the last 12 months. A plan will be developed by 10/16/18 for the implementation for testing and training. IDENTIFICATION OF OTHERS No other policy and procedure affected SYSTEMIC CHANGE NHA or designee will continue with verification of training and testing as appropriate. MONITORING NHA or designee will verify training and testing with participation records and times and report when appropriate to QAPI	10/16/2018, AS	

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NAME OF PROVIDER OR SUPPLIER SHERIDAN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1851 BIG HORN AVE SHERIDAN, WY 82801		
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E 038	Continued From page 2 requirements for evacuation drills and training at §483.470(h). *(For ESRD Facilities at §494.62(d):) Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to develop and maintain an emergency preparedness training and testing program. The findings were: Document review of the Emergency Preparedness Plan on 09/12/18 at 1:55 PM revealed that no training or testing program had been developed, or was being implemented at the facility. Interview with the facility administrator acknowledged that they were missing documentation, but he believed training of the emergency preparedness plan was being conducted with employees. He also believed a tabletop exercise had been conducted in the last twelve months.	E 038			