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 _____	09/07/2005

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

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K 000	INITIAL COMMENTS Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with an automatic supervised dry sprinkler system and fire alarm system. K6: Date of Plan Approval: 1962 and 1988 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=128;SNF/NF=128 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	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. This Plan of Correction is the facility's credible allegation of compliance.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview on 9/07/05, the facility failed to test the emergency battery light system in accordance with NFPA 101 Section 7.9.3. The findings were: 1. Review of maintenance records revealed the annual 90-minute emergency battery light test had not been conducted in the past year. Interview with a member of the maintenance staff	K 046	**TAG K046 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide emergency lighting. 1. The maintenance staff was instructed to test the battery light in the boiler room for 90 minutes at least annually and to document such testing. 2. The battery light was tested for 90 minutes on 9/19/05. This test was recorded. 3. The Safety Committee will review the completion of tests of emergency lighting on an annual basis.	9/19/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Schulz | TITLE: Administrator | (X6) DATE: 9/29/05

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.

ACCEPTANCE OF THE POC WITH DIANE SAMUEL, NHA, ON 10/10/05 @ 2pm VIA TELECONFERENCE.

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K 046	Continued From page 1 at 10:44 AM revealed they were not aware the battery light had to be left running on the battery for the 1 1/2 hours. They thought the test was performed when ever the generator was run under load.	K 046		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations the facility was not fully sprinkled as required by NFPA 13 Section 5-1.1. The findings were: Observation on 9/7/05 revealed the following concerns: 1. At 11:03 AM, the small closet in resident room #510 was noted not to have sprinkler coverage. 2. At 1:49 PM, the two walk-in refrigerator units in the kitchen did not have sprinkler coverage.	K 056	**TAG K056 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide an automatic sprinkler system to provide coverage for all portions of the building. 1. Sprinkler coverage will be provided for the small closet in resident room 510 and the two refrigeration units in the kitchen. 2. Plans for the installation of sprinkler coverage were obtained from the installation contractor on 9/19/05. See Attachment A and B. 3. Plans for installation of sprinkler coverage were faxed to Milt Werner at the Wyoming Department of Health on 9/21/05 for Department approval. 4. Installation will begin when plans are approved by the Wyoming Department of Health. A completion time extension will be requested if plan approval by the Department is delayed.	10/07/05

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K 064	Continued From page 2	K 064		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain and test 2 of 23 portable fire extinguishers in accordance with NFPA 10 Section 4-4.4.2 and 2-3.2 respectively. The findings were. 1. Observation on 9/7/05 revealed 1:53 PM, the kitchen's ABC type portable fire extinguisher near the hood had a verification of service collar which was broken and was not an uninterrupted circle. 2. Observation on 9/7/05 at 1:57 PM revealed the kitchen used combustible cooking media and was not equipped by a K-type portable fire extinguisher.	K 064	**TAG K064 – PLAN OF CORRECTION** It is the policy and practice to provide portable fire extinguishers which are maintained according to NFPA 10. 1. All fire extinguishers will be inspected monthly to assure that verification of service collars are intact. 2. The kitchen ABC fire extinguisher, located near the hood, was replaced by a K-type portable extinguisher on 9/14/05. 3. The Safety Committee will Audit the condition of verification of service collars quarterly. 4. The Administrator will review the audits of the Safety Committee and direct corrective action as needed.	9/14/05
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99	K 076	**TAG K076 – PLAN OF CORRECTION** It is the policy and practice of this Facility to provide medical gas storage and administration areas which are protected in accordance with NFPA 99. 1. The Staff Development Coordinator will provide additional inservice training for all nursing, housekeeping, maintenance and supervisory personnel on the proper	10/07/05

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K 076	Continued From page 3 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide proper oxygen storage for 1 of 14 oxygen cylinders in accordance with NFPA 99 Section 4-3.1.1.1. The findings were: 1. Observation on 9/7/05 at 12:16 PM revealed the tub room near resident room #420 had one oxygen cylinder which was not restrained.	K 076	storage of oxygen cylinders. 2. The Safety Committee will direct the inspection of oxygen storage areas on a monthly and random basis for the proper storage of cylinders. 3. The Staff Development Coordinator will review audits of the Safety Committee and direct corrective action and further inservice as needed.	
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	**TAG K143 – PLAN OF CORRECTION** It is the policy and practice of this facility to provide storage of oxygen transferring according to NFPA 99. 1. Mechanical ventilation will be provided for the mechanical oxygen transferring room. 2. Plans for installation of mechanical ventilation will be obtained by the contractor. Plans will be presented to Milt Werner at the Wyoming Department of Health. 3. Installation will begin when plans are approved by the Wyoming Department of Health. A completion time extension will be requested if plan approval by the Department is delayed. 4. The Maintenance Department is responsible for the	10/07/05

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K 143	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation the facility failed to ventilate the liquid oxygen storage area in accordance with NFPA 99 Section 8-6.2.5.2. The findings were: 1. Observation on 9/7/05 at 2:20 PM revealed the liquid oxygen storage room lacked mechanical ventilation.	K 143		