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JUL 17 2012
Healthcare Licensing
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PRINTED: 07/06/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(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 sprinkled three story building of Type V (111) and II (111) construction built in 1965 and 1987. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and an addressable fire alarm system. The facility had a capacity of 150 certified Medicare and Medicaid beds with a census of 111.	K 000		
K 012 SS=D	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 rooms were smoke resistant in 1 of 10 smoke compartments. The findings were: 1, Observation of the medical technician office on 6/19/12 at 8:56 AM showed there were two unsealed cable penetrations. The largest gap measured 1 inch by 4 inches. At the time of the observation maintenance technician #1 could not explain why the gaps had not been noticed and repaired during the monthly inspections.	K 012	**K012 Ensure rooms were smoke resistant.** The facility will ensure this will occur by the following: • Penetration sealed in medical technician office with fire caulking 06/28/12 • Penetration sealed in data router room with fire caulking_06/28/12 Identification of other residents will occur by: • All residents are equally affected by fire prevention and life safety guidelines. **Systemic process:** • Preventive maintenance rounds monthly will continue to look for penetrations and repair. Documentation per computerized log • Inspection by plant operations when repair, construction or new technology installed to ensure penetrations repaired prior to vendor leaving premises **Outcome:** Plant operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventive maintenance software program and report to Environment of Care committee and QA committee quarterly	07/27/12

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

LWHA — Administrator — 7/16/12

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.

POC ACCEPTED W/ EDIT BY LWHA, ON 7/17/12.

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K 012	Continued From page 1 2. Observation of the second floor data router room on 6/19/12 at 9:05 AM showed there was a 3 inch by 8 inch hole in the wall. At the time of the observation maintenance technician #1 could not explain why the holes had not been noticed and repaired during the monthly inspections.	K 012	K018. Ensure corridor doors are smoke resistant The facility will ensure this will occur by the following: **Neighborhood One** **Residents #111,110,108,106** • Doors trimmed and kickplate trimmed to ensure unobstructed closure 07/10/12 • Doors tested for unobstructed closure Identification of other residents will occur by: • All residents are equally affected by fire prevention and life safety guidelines. **Systemic process:** • Preventive maintenance rounds monthly will continue to look for unobstructed door closures. Documentation per computerized log • Neighborhood one doors all have been painted and will be tested for unobstructed closure. All doors on Neighborhood One to be tested and repaired as needed July 27, 2012 • Any doors with obstructed closure will have work orders generated via computerized work order system to repair doors that have obstructed closure **Outcome:** Plant operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventive maintenance software program and report to Environment of Care committee and QA committee quarterly	07/27/12
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 3 of 10 smoke compartments. The findings were:	K 018		

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K 018	Continued From page 2 Observation on 6/19/12 between 9 AM and 10 AM showed the following corridor doors required excessive force to close: a. Resident room #111 b. Resident room #110 c. Resident room #108 d. Resident room #106 At 9:23 AM maintenance technician #1 reported the resident room corridor doors were not routinely inspected. He further reported the aforementioned doors were recently painted and this may have caused the additional friction.	K 018		07/27/12
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the stairwell tower was smoke resistant. The findings were: Observation of the stairwell towers on 6/19/12 at 8:22 AM showed a ¼ inch unsealed conduit penetration above the second floor landing. At the time of the observation the maintenance technician #1 could not explain why the gap had not been noticed and replaced during the monthly inspections.	K 020	K020 ensure stairwell tower was smoke resistant The facility will ensure this will occur by the following: • Penetration sealed in stairwell with fire caulking 06/26/12 Identification of other residents will occur by: • All residents are equally affected by fire prevention and life safety guidelines. Systemic process: • Preventive maintenance rounds monthly will continue to look for penetrations and repair. Documentation per computerized log • Inspection by plant operations when repair, construction or new technology installed to ensure penetrations repaired prior to vendor leaving premises Outcome: Plant operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventive maintenance software program and report to Environment of Care committee and QA committee quarterly	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 3 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.6.4 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 separated from use areas in 2 of 10 smoke compartments. The findings were: 1. Observation on 6/19/12 between 8:30 AM and 9 AM showed the maintenance storeroom and old pharmacy storeroom were both greater than 50 square feet and held combustible items. Further observation showed neither of the corridor doors were equipped with self-closing devices. At 8:34 AM maintenance technician #1 reported he was unaware self-closing devices were required on all storeroom doors, larger than 50 square feet. 2. Observation of wing #1 medication room on 6/19/12 at 9:41 AM showed four unsealed cable penetrations. The largest gap measured 2 inch by 3 inches. At the time of the observation maintenance technician #1 reported the medication rooms were not routinely inspected.	K 029	**K029 Ensure hazardous areas were separated from use area. The facility will ensure this will occur by the following:** • Self equipping closure placed on pharmacy storeroom and plant operations store room 06/25/12 • Unsealed cable penetrations in wing #1 med room sealed with fire caulk 06/25/12 **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines. **Systemic process:** • Preventive maintenance rounds monthly • Documentation per computerized log • Identify other storerooms with 50 square feet and place self equipping closures on the storerooms **Outcome:** Plant operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventive maintenance software program and report to Environment of Care committee and QA committee quarterly	07/27/12
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 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 observation and staff interview, the facility failed to ensure corridors were cleared and made ready for evacuation during a fire drill in 1 of 10 smoke compartments. The findings were; Observation of the fire drill on 6/19/12 at 1:17 PM showed the simulated fire was in resident room #310. Further observation showed a hoyer lift and nutrition cart were left in the 500 wing corridor throughout the drill. At the time of the observation the administrator reported he was unaware all corridors were required to be cleared with the activation of the fire alarm system. Reference NFPA 101, 2000 Edition; 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area,	K 050	**K050 Ensure corridors cleared and made ready for evacuation during a fire drill. The facility will ensure this will occur by:** • Just in time training for all staff at that moment working regarding appropriate response to fire drill June 19,2012 **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines **Systemic process:** • Staff education regarding fire drill expectations and policy July 26, 2012 • First Day orientation to be revised to include roles and responsibilities during fire drill • Staff education regarding access of policy manager and computer usage • Review and revise fire prevention and fire drill policy to include corridor being clear during fire drill or fire • Annual mandatory fire drill training for all staff • Fire plan policy review and revision **Outcome: 100% of staff will respond appropriately to fire drills** Plant Operations will collect data related to fire drill response Data will be reviewed quarterly at Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	07/27/12

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K 050	Continued From page 5 and the relocation of patients as detailed in the health care occupancy's fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. A.19.2.3.3 It is not the intent that the required corridor width be maintained clear and unobstructed at all times. Projections into the required width are permitted by the exception to 7.3.2. It is not the intent that 19.2.3.3 supersede 7.3.2. Also, it is recognized that wheeled items in use (such as food service carts, housekeeping carts, gurneys, beds, and similar items) and wheeled crash carts not in use (because they need to be immediately accessible during a clinical emergency) are encountered in health care occupancy corridors. The health care occupancy's fire plan and training program should address the relocation of these items during a fire. Note that "not in use" is not the same as " in storage." Storage is not permitted to be open to the corridor unless it meets one of the exceptions	K 050		

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K 050	Continued From page 6 to 19.3.6.1 and is not a hazardous area.	K 050		
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 sprinkler heads with foreign material on them were replaced in 1 of 10 smoke compartments. The findings were: Observation of the classroom on 6/19/12 at 8:47 AM showed one of two sprinkler heads had sheet rock texture sprayed on it. At the time of the observation maintenance technician #1 reported the sprinkler system was inspected annually by an outside contractor to ensure heads that were damaged, corroded, or had foreign material were replaced. He could not explain why this head was not replaced. Reference NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1999 Edition; 2-2.1.1* Sprinklers shall be visually inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged or loaded, or in the improper orientation.	K 062	07/27/12 K062 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 **The facility will ensure this will occur by:** • Sprinkler head in classroom with sheetrock on the head. Fire suppression vendor notified to repair sprinkler head. Sprinkler head repaired prior to submission of this report, pictures submitted **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines **Systemic process:** • Quarterly PM inspection by Plant Ops staff of sprinklers, obstructions, ceiling storage standards per preventive maintenance program • Annual inspection by outside contractor with specific expectation regarding ceiling and sprinkler obstructions • Staff education regarding CMS standards/Life Safety codes related to sprinkler heads, ceiling storage and PM expectations. **Outcome:** 100% of sprinkler heads will be unobstructed Plant Operations will collect data related to sprinkler head function/unobstructed field of spray Data will be reviewed quarterly at Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly.	
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

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K 064 SS=D	Continued From page 7 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 and staff interview, the facility failed to ensure portable fire extinguishers were inspected on a monthly basis in 1 of 10 smoke compartments. The findings were: Observation of the activities storeroom on 6/19/12 at 8:39 AM showed the portable fire extinguisher last annual service was conducted in July 2011. Further observation showed a monthly inspection had not occurred since the annual service. At the time of the observation maintenance technician #1 could not explain why the monthly inspection had not occurred. Reference NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition: 4-3 Inspection. 4-3.1 Frequency. Extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals	K 064	**K064 Ensure portable fire extinguishers are inspected on a monthly basis.** **The facility will ensure this will occur by:** **Activities storeroom** • Removal of stove in activities storeroom • Inspection of all facility fire extinguishers July 6, 2012 • Fire extinguisher inspected by security officer • Remove fire extinguisher from activities storeroom **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines **Systemic process:** • **Continue inspection schedule of fire extinguishers per monthly schedule** **Outcome:** 100% of fire extinguishers in facility will be inspected on monthly schedule and annually per fire marshall recommendations Plant Operations will collect data related to fire extinguishers Data will be reviewed quarterly at Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	07/27/12
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.	K 141		

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K 141	Continued From page 8 This STANDARD is not met as evidenced by: Based on policy review, observation, and staff interview, the facility failed to ensure resident rooms with oxygen in use were posted with No Smoking signs in 1 of 10 smoke compartments. The findings were: Review of the facility's smoking policy showed section 1. (d) states, "Smoking is prohibited in any area where oxygen is being used or stored ..." Observation on 6/19/12 at 10:20 AM showed the facility did have an indoor smoking room, which requires the posting of all rooms where oxygen is used or stored with a No Smoking sign. Observation of resident room #304 and #303 on 6/19/12 between 10 AM and 10:30 AM showed oxygen was in use in both rooms and neither room was posted with a No Smoking sign. At the time of the observation maintenance technician #1 could not explain why the signs had not been posted. No Smoking signs were posted at the time of observation.	K 141	**K141Ensure resident rooms with oxygen in use were posted with NO Smoking signs** **The facility will ensure this will occur by:** **Resident rooms 303 and 304** • Nonsmoking signs placed on resident rooms 303 and 304 June 19, 2012 **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines **Systemic process:** • All rooms will have nonsmoking signs placed to facilitate nonsmoking in the presence of oxygen Aug 1, 2012 • Plan for new construction to have tobacco free facility with signs posted on all entrances 2014	07/27/12
K 147 SS=D	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 electrical outlets in wet locations had ground fault circuit interrupter (GFCI) protection in 1 of 10 smoke compartments. The findings were: Observation of the skills classroom on 6/19/12 at 8:54 AM showed an outlet located 12 inches from	K 147	**Outcome:** 100% of rooms and common areas in facility have No smoking signs on the doors Plant Operations will collect data related to No smoking signs Data will be reviewed quarterly at Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	

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K 147	Continued From page 9 the sink did not have GFCI protection. At the time of the observation maintenance technician #1 could not explain why the outlet had not been noticed and replaced during the monthly inspections. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 517-20. Wet Locations. (a) All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption or power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated.	K 147	**K147Ensure electrical outlets in wet locations have ground fault circuit interrupter (GFCI) protection** **The facility will ensure this will occur by:** **CNA skills lab** • GFCI outlet placed in skills lab by sink 06/21/12 **Identification of other residents will occur by:** • All residents are equally affected by fire prevention and life safety guidelines **Systemic process:** • **All outlets in facility inspected 07/12/12 All outlets/wet areas appropriate to GFCI standard** • **All remodeling or construction will have inspection by plant operations prior to vendor leaving the premises to include ensuring appropriate electrical outlets installed** **Outcome: 100% of wet areas have GFCI outlets** Plant Operations will collect data related to GFCI outlets Data will be reviewed semiannually at Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	07/27/12