PRINTED: 06/18/2013
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 B. WING	06/05/2013

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 sprinklered, three story building of Type V (111) and II (111) construction built in 1965 and 1967, respectively. The building was equipped with a supervised, automatic wet sprinkler system with an anti-freeze loop and an addressable fire alarm system. The facility had a capacity of 150 certified Medicare and Medicaid beds with a census of 118 residents.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 3 fire barriers were equipped with fire rated hardware. The findings were: 1 Observation of the second floor apartment fire barrier door on 6/4/13 at 3:34 PM showed the panic crash bar was not provided with a fire rated	K 011	K 011 Correction for cited deficiency: Fire rated hardware inspected and assured that identifying tags are in place. Strike plates corrected to permit unimpeded closure. All residents and staff are potentially affected by the fire prevention and life safety guidelines Systemic Corrective Action: • Plant Operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventative maintenance software program. Outcome: ➢ 100% of fire barriers will have fire rated hardware with identifying tags in place. ➢ 100% of fire barrier doors will have unimpeded strike plates and free of locking mechanisms with functioning smoke barriers. Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	07-20-13 07-20-13 07-20-13 07-20-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 6/28/13

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/ JONI BELDEN, NHA ON 7/01/13.

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

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K 011	Continued From page 1 label. At the time of the observation maintenance technician #1 reported the door was originally provided with a fire rated adhesive label that must have been removed. He could not provide additional documentation that the panic hardware was rated. 2. Observation of the wing #5 dining room fire barrier double doors on 6/5/13 at 11:04 AM showed the doors were equipped with top and bottom latching hardware. Further observation showed the floor receiving strike plates had been covered with carpet. At the time of the observation the plant operations manager could not explain why the strike plates had not been maintained with the installation of the carpet. Reference NFPA 101; 2000 Edition, 19.2.2.2.1; 7.2.1.7.2 Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors. Fire exit hardware is tested for use on fire-rated doors; panic hardware is not. 7.2.1.7.3 Required panic hardware and fire exit hardware shall not be equipped with any locking device, set screw, or other arrangement that prevents the release of the latch when pressure is applied to the releasing device. Devices that hold the latch in the retracted position shall be prohibited on fire exit hardware unless listed and approved for that purpose.	K 011		
K 018 SS=D	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	K 018	K 018 Correction for cited deficiency: Doors to conference area adjusted to assure they are smoke resistant with astragal installed. All residents and staff are potentially affected by the fire prevention and life safety guidelines. Systemic Corrective Action: • Plant Operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventative maintenance software program. Outcome ➢ 100% of corridor doors will provide smoke resistant capabilities, close appropriately and/or have astragals in place to provide smoke barriers according to state and federal guidelines. Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	07-20-13 07-20-13 07-20-13

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K 018	Continued From page 2 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 1 of 10 smoke compartments. The findings were: Observation of the Lilac room on 6/6/13 at 11:45 AM showed a ⅛ inch gap between the corridor doors. At the time of the observation maintenance technician #1 could not explain why the gap had not been noticed and repaired during the monthly safety inspections.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass	K 025	K 025 Correction for cited deficiency: Chapel smoke barrier penetration sealed. 500 wing smoke barrier penetration sealed. All residents and staff are potentially affected by the fire prevention and life safety guidelines.	07-20-13 07-20-13 07-20-13

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K 025	Continued From page 3 panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were: Observation of smoke barrier walls on 6/5/13 between 10 AM and 11 AM showed the following walls had unsealed penetrations: a. The chapel smoke barrier had a 2 inch by 6 inch unsealed penetration. b. The 500 wing central smoke barrier had a 2 inch unsealed cable penetration. On 6/5/13 at 10:09 AM maintenance technician #1 could not explain why the aforementioned unsealed penetrations had not been noticed and repaired during the annual safety inspection.	K 025	K025 continued Systemic Corrective Action: • All vendors performing changes to the facility will perform an exit inspection with members of the Plant Operations dept utilizing the above ceiling and penetration process. 07-20-13 • Plant Operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventative maintenance software program. 07-20-13 • Staff education regarding above ceiling penetration process. 07-20-13 Outcome ➢ 100% of fire barriers will be sealed in accordance with life safety codes. Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	K 027		

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K 027	Continued From page 4 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure smoke barrier doors were smoke resistant in 1 of 8 smoke barrier walls. The findings were: Observation of wing #2 smoke barrier on 6/6/13 at 9:16 AM showed the double doors were equipped with a brush type astragal. Further observation showed a ¼ inch gap between the doors/astragals. At the time of the observation maintenance technician #1 could not explain why the gap had not been noticed and repaired during the monthly safety inspections.	K 027	K 027 Correction of cited deficiency: Wing 2 barrier double doors and astragal adjusted to ensure appropriate smoke barrier function. All residents and staff are potentially affected by the fire prevention and life safety guidelines. Systemic Corrective Action: • Plant Operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventative maintenance software program. Outcome: ➢ 100% of corridor doors will provide smoke resistant capabilities, close appropriately and/or have astragals in place to provide smoke barriers according to state and federal guidelines. ➢ Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	07-20-13 07-20-13 07-20-13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to test 1 of 7 fire alarm system	K 052		

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K 052	Continued From page 5 components. The findings were: Review of the fire alarm system testing records showed the fire alarm battery semi-annual load voltage test was last performed on 6/21/12, more than six months ago. On 6/5/13 at 1:10 PM maintenance technician #1 reported he was unaware the load voltage test was a semi-annual requirement. Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; Table 7-3.2 Testing Frequencies. 6. Batteries-Fire alarm systems d. Sealed Lead-Acid Type 1. Charge Test,.....annually (Replace batteries every 4 years.) 2. Discharge Test ... ...annually (30 minutes) 3. Load Voltage Test,.....semi-annually	K 052	K 052 Correction for cited deficiency: Implement semiannual fire alarm battery load voltage testing. All residents and staff are potentially affected by the fire prevention and life safety guidelines. Systemic Corrective Action: • Plant Operations staff will maintain log of fire alarm battery testing per NFPA 101 Life Safety Code in the Preventative Maintenance software program. Outcome: ➢ 100% of fire alarm battery testing will be completed semiannually per NFPA 101 Life Safety Codes. Plant Operations staff or designee will collect data and evaluation will be reported semiannually to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	07-20-13 07-20-13 07-20-13
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 temporary electrical wiring did not replace permanent fixed wiring in 3 of 10 smoke compartments. The findings were: 1 Observation of the electrical system on 6/4/13 between 3:30 PM and 5:30 PM showed the following locations had prohibited electrical adapters in use: a. The conference room had a computer plugged	K 147		

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K 147	Continued From page 6 into a 3-way adapter. b. The wing #1 nurses ' station computer was plugged into two uninterrupted power supply (UPS) surge protected devices, in-line. On 6/4/13 at 3:42 PM maintenance technician #1 could not explain why the aforementioned electrical adapter had not been noticed and removed during the monthly safety inspections. 2. Observation of the beauty shop on 6/4/13 at 4:02 PM showed a 15 amp surge protector was overloaded by appliances. Two 12 amp curling irons and one 15 amp hair drier were all plugged into the surge protector. Further observation showed the area did not have adequate electrical receptacles for the total number of appliances. At the time of the observation maintenance technician #1 reported the beauty shop was not routinely inspected to ensure electrical appliances did not overload surge protectors. Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	K 147 Correction for cited deficiency: 3-way adapter in computer room removed and computer connected to approved electrical source. Wing 1 nurses station computer connected to approved electrical source. Temporary electrical wiring replaced with permanent fixed wiring in beautician work area. All residents and staff are potentially affected by the fire prevention and life safety guidelines. Systemic Corrective Action: • Beauty shop work area and the computer training room to be added to the existing Leadership and Safety rounds. • Staff education on appropriate use of temporary electrical devices. • Safety Coach will complete monthly inspection of all fire hazards and electrical connections utilizing the safety coach and Leadership rounds form.. Outcome: ➢ 100% of electrical devices will be connected to approved NFPA 101 Life Safety Code outlets. Plant Operations staff or designee will collect data and evaluation will be reported quarterly to the Environment of Care Committee and QA Committee with discrepancies investigated and resolved.	07-20-13 06-07-13 07-20-13 07-20-13 07-20-13 07-20-13 07-20-13