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	08/28/2014

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 1987, 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 052 SS=D	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 review of fire alarm testing and maintenance records and staff interview, the facility failed to provide documentation identifying the required semi-annual battery load voltage	K 052	**LSC Federal Plan of Correction** **K052** **10/12/14** **Correction for cited residents/areas:** New battery installed July 2014. Next semiannual testing due January 2015. **Identification of other residents will occur by:** All residents have the potential to be affected by maintenance and testing of the fire alarm and suppression system. **Systemic Corrective Action:** 1. The semiannual battery load voltage testing will be added to the electronic preventive maintenance system in order to provide an auditing process for external vendor. 2. Incorporate maintenance records into Accreditation Readiness preparation. **Outcome:** 100% of required testing documentation for fire alarm and suppression system per NFPA guidelines Life Safety officer will verify all required life safety maintenance records for any outside vendors monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 9/23/14

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 per Phone Call with Jonni Belden (Administrator) On 10/2/14 @ 203pm. SZ

JWyatt

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K 052	Continued From page 1 testing in compliance with the requirements of NFPA 72. The findings were: Review on 08/28/14 from 08:45 AM to 10:00 AM of the fire alarm testing and maintenance records revealed the absence of one semi-annual battery load test in 2014 as required by NFPA 72-1999, Section 7-3.2 (6). At the time of the review, the Facility Maintenance Director acknowledged the lack of documentation for the battery load test.	K 052		
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 observation and staff interview, the facility failed to ensure there was adequate sprinkler coverage in 1 of 10 smoke compartments. The findings were: Observation of the Walk In Cooler in the kitchen area on 08/27/14 at 3:34 PM showed the sprinkler head had been removed from inside the	K 056	**K056** **10/12/14** **Correction for cited residents/areas:** Sprinkler head replacement by outside vendor in the Walk-in cooler in the kitchen. **Identification of other residents will occur by:** All residents have the potential to be affected by maintenance of the fire alarm and suppression system. **Systemic Corrective Action:** 1. Vendor review of building fire suppression system to identify opportunities for improvement 2. Leadership rounds to include fire sprinklers review and inspection 3.Develop standard required maintenance log resource manual and log. **Outcome:** 100% fire sprinklers will be in working condition and free of impediment to disbursement of water. Administrator or designees will collect data on leadership rounds monthly. Life Safety officer will audit maintenance logs and records and report to Environment of Care quarterly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	

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K 056	Continued From page 2 Walk In Cooler. At the time of the observation, the Facility Maintenance Director acknowledged that the sprinkler head had been removed from the Walk In Cooler. Reference: NFPA 13, 5-1.1 1999 Edition	K 056		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on document review & staff interview, the facility failed to ensure that HVAC systems are tested per the requirements of NFPA 90A. The findings were: Document review and staff interview on 08/28/14 between 08:45 AM and 10:00 AM revealed that no documentation was available to indicate that fire dampers are being tested on a 4-year basis in accordance with NFPA 90A, Section 3-4.7. Interview with the Facility Maintenance Director at the time of document review acknowledged the missing documentation.	K 067	**K067** **10/12/14** **Correction for cited residents/areas:** Vendor to complete Fire Damper testing for all areas in the building **Identification of other residents will occur by:** All residents have the potential to be affected by maintenance and testing of the fire alarm and suppression system. **Systemic Corrective Action:** 1.Fire Damper testing to be entered into the electronic preventive maintenance system in order to provide an auditing process for external vendor. 2. Incorporate maintenance records into Accreditation Readiness preparation. **Outcome:** 100% of required testing for fire alarm and suppression system per NFPA guidelines Plant operations personnel will verify logs and reports for any outside vendors monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide door hardware that were operable with only one action and without tight pinching to operate. The findings were: Observation of Room #103 door on 08/27/14 at 1:33 PM, the Wing 1 Shower Room on 08/27/14 at 1:36 PM, and Room #104 on 08/27/14 at 1:52 PM revealed a thumb-turn lock on the door knob. The action of the knob did not release the lock in one release action and the thumb-turn lock required tight pinching to release. Interview with the Facility Maintenance Director at the time of the observation acknowledged the door hardware. REFERENCE NFPA 101 Life Safety Code, 2000 Edition 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. A.7.2.1.5.4 Examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This requirement is permitted to be satisfied by the use of conventional types of hardware, whereby the door is released by turning a lever, knob, or handle or by pushing against a panic bar, but not by unfamiliar methods of operation such as a blow to break glass. The operating devices should be capable of being operated with one hand and should not require tight grasping, tight pinching, or twisting of	K 130	**K130** **10/12/14** **Correction for cited residents/areas:** 1. Room #103 door hardware changed to be operable with only one action and without tight pinching to operate 2. Wing 1 Shower Room door hardware changed to be operable with only one action and without tight pinching to operate. 3. Room #104 door hardware changed to be operable with only one action and without tight pinching to operate. **Identification of other residents will occur by:** All residents have the potential to be affected by door hardware that fails to operate with only one action and tight pinching mechanism. **Systemic Corrective Action:** 1.Review all resident care areas to ensure doors are provided with a releasing device without more than one releasing operation. 2.Replace any door hardware in resident care areas to have only one action and without tight pinching to operate 3.Revise leadership rounds to include door handle inspection. **Outcome:** Administrator or designee will collect data on the Leadership rounds monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	

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K 130	Continued From page 4 the wrist to operate.	K 130		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure weekly maintenance inspections were being performed for the generator. Document review and interview on 08/28/14 at 08:45 AM to 10:00 AM revealed the records for the generator did not ascertain performing the weekly inspections. There were no detailed checklists of the inspection as recommended by NFPA 110 provided with the records. Interview with the Facility Maintenance Director during the document review confirmed that the weekly maintenance inspections were not documented.	K 144	**K144** **Correction for cited residents/areas:** Developed weekly inspection log for generator inspection completed by plant operations personnel with documentation of action plan for any deficiencies. **Identification of other residents will occur by:** All residents have the potential to be affected by maintenance and testing of the generator system. **Systemic Corrective Action:** 1. Complete weekly inspection of the generator in addition to monthly testing program 2. Enter inspections into electronic preventive maintenance system with deficiencies remediation documentation. 3. Incorporate maintenance records into Accreditation Readiness preparation. **Outcome:** 100% of weekly inspection log completed for generator system Plant operations personnel will verify logs completion/documentation monthly Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	10/12/14