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 _____	10/08/2014

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 Stories: 1 Construction: Type V(111) and II(000) Constructed: 1965, 1985 addition K0180: Fully Sprinkled Certified Beds: 150 Capacity: 125 Census: 116	K 000	K029 Correction for cited areas: 1. Laundry cart Storage area: Self closure device installation on door 2. Wing 2 Laundry room: Self closure device installation on the door	11/19/14
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 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 interview, the facility failed to protect hazardous areas as required. Findings include: On 10/8/14, the following storage rooms were found to have doors that were not self-closing. Storage rooms that exceed 50 sf in size and contain combustible materials are considered hazardous areas. Doors to hazardous areas are required to be self-closing.	K 029	Identification of other locations/residents will occur by: 1.All residents have the potential to be affected by doors to storage areas greater than 50 sf storing hazardous materials without self closure devices. Systemic Corrective Action: 1.Leadership rounds to include self closure devices for rooms greater than 50 sf with combustible materials Outcome: 1.100% storage areas with greater than 50sf with combustible items will have self closure devices. 2. Life Safety officer will audit storage areas quarterly for self closure device functioning. 3. 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 | (X5) DATE

Jonni Beldean RN/LNHA | Administrator | 10/27/14

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.

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K 029	Continued From page 1 · Laundry cart storage area in the lower level was not self-closing as required. · Wing 2 laundry room used for storage 70 square feet Maintenance Mechanic II was present when the deficiency was identified. Failure to protect hazardous areas as required increases the risk of death or injury due to fire. The deficiency affected two of numerous locations in the building. Ref: 2000 NFPA 101 Section 19.3.2.1	K 029	K038 Correction for cited areas 1. Wing 5 dining courtyard door locking hardware replaced with hardware that allows for accessibility at all times as a means of egress from the inner courtyard. 2.Dr. Meade office hardware changed to be operable with only one action and without tight pinching to operate. Identification of other areas/residents will occur by: 1. All residents have the potential to be affected by door hardware that fails to operate with only one action and tight pinching mechanism. 2. All residents have the potential to be affected by accessiblity of egress.	11/19/14
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress as required. Findings include: On 10/8/14 the doors to the Wing 5 dining courtyard on the upper and lower level were equipped with a lock in that required a key in the	K 038	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 3. Revise leadership rounds to include door handle inspection	

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K 038	Continued From page 2 direction of egress. Doors in the means of egress are not permitted to be equipped with a lock or latch that requires the use of a key in the direction of egress. Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 19.2.2.2.4 On 10/8/14 the following doors were equipped with two locking/ latching devices where two releasing operations were required to operate the door. Doors in the means of egress are required to be operable with not more than one releasing operation. · Dr. Meads Office Ref: 2000 NFPA 101 Section 19.2.1, 7.2.1.5.4 Maintenance Mechanic II was present when the deficiency was identified. Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected three of numerous doors in the means of egress.	K 038	K038 continued Outcome: 1. Administrator or designee will collect data on the leadership rounds monthly 2. Life Safety coach will audit findings quarterly 3. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved K048 Correction for cited areas: 1. Definition of smoke compartment added to fire plan policy to clarify definition. Identification of other areas/residents will occur by: 1. All residents/staff have the potential to be affected by a written plan for the protection of all residents/staff and evacuation procedures.	11/19/14
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have a fire plan as required.	K 048	Systemic Corrective Action: 1. Revise policy to clarify definition of smoke compartment 2. Review all other fire related policies to determine if any other policies require clarification.	

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K 048	Continued From page 3 Findings include: On 10/8/14 the fire plan did provide for evacuation of smoke compartment as required. Maintenance Mechanic II was present when the deficiency was identified. Failure to have a fire plan as required increases the risk of death or injury due to fire. The deficiency affected one of eight required provisions. Ref: 2000 NFPA 101 Section 19.7.1.1, 19.7.2.2	K 048	K048 continued Outcome: 1. Fire plan will have definitions clarified on the policy in order to ensure appropriate communication and guidance. 2. Fire plan will be reviewed every two years by Environment of Care committee.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3	K 074		

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K 074	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to insure that curtains in the facility were flame resistant per 1999 NFPA 701 as required. Findings include: On 10/8/14 curtains were identified in 29 locations that were not tagged as meeting flame resistance requirement. The provider had evidence that in the past a program was in force to treat the subject curtains so that they met the specified requirement. Maintenance Mechanic II related that this program was not continued due to changes in staff and lack of training of new staff. Maintenance Mechanic II was present when the deficiency was identified. Failure to provide curtains that meet flame resistance as required increases the risk of death or injury due to fire. The deficiency affected 29 of numerous locations in the building. Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1	K 074	K074 Correction for cited areas: 100% of draperies will be in accordance with provisions of 10.3.1 and NFPA 13 Identification of other areas/residents will occur by: All residents and staff have the potential to be affected by failure to provide curtains that do not meet fire resistant in accordance with 10.3.1 and NFPA 13 Systemic Corrective Action: 1.Inspection of 100% areas with curtains and replace curtains with fire resistance curtains 2. Inspect the bathroom and curtain dividers to ensure the curtains are in accordance with 10.3.1 and NFPA 13 Outcome: 1. Environmental Supervisor or designee will audit draperies and curtains monthly. 2. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	11/19/14