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

PRINTED: 10/07/2015
FORM APPROVED
OMB NO. 0938-0391

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 _____	09/23/2015

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, single story building of Type V (111) and Type II (000) construction built in 1965 and 1985. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 150 certified Medicare and Medicaid beds with a census of 116.	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	K017 **Correction for cited area:** 11/22/015 3"x3" area above the water fountain repaired Penetrations from speaker wires sealed. **Identification of other residents:** All residents have the potential to be affected by penetrations in the walls and smoke penetration **Systematic Changes and Monitoring:** Above ceiling permits to be obtained when work is done above the ceiling Any repair work will include inspection of surrounding areas to see if any penetrations. **Outcome:** Life Safety officer will randomly inspect above ceiling areas for penetrations 100% of identified penetrations will be repaired upon identification 100% of new work will be sealed prior to approval of completion of project. Plant operations will collect data and report to long term care Quality committee quarterly and discrepancies investigated and resolved.	

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

Jonni Bilden — Administrator — 10/16/15

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.

RECEIVED
WY Dept of Health
OCT 19 2015
Healthcare Licensing and Surveys

POC Accepted VIA Phone with Administrator Jonni Bilden on 10/28/15 @ 9:42AM.

34354

FORM CMS-2567(02-99) Previous Versions Obsolete — Event ID: NK3W21 — Facility ID: WY0021 — If continuation sheet Page 1 of 5

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K 017	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor walls were smoke resistant in 1 of 9 smoke compartments. The findings were: Observation of the corridor walls above the drop down ceiling on the maintenance corridor on 09/22/15 from 9:45 AM to 10:00 AM revealed a 3" X 3" penetration directly above the water fountain. Additional penetrations were located at each smoke detector location. Wires from the smoke detectors penetrated the corridor walls, but were not sealed to maintain a smoke resistant barrier. At the time of the observations the Facility Maintenance Manager acknowledged the multiple penetrations in the corridor walls. Ref: 2000 NFPA 101, Section 19.3.6.2.1	K 017	**K038 Correction for cited residents:** 11/22/15 **Correction for cited residents/areas:** 1. CNA classroom door hardware changed to be operable with only one action and without tight pinching to operate 2. EVS supervisor door hardware changed to be operable with only one action and without tight pinching to operate. 3. Transportation office door hardware changed to be operable with only one action and without tight pinching to operate. 4. Clean storage in maintenance corridor changed to be operable with only one action and without tight pinching to operate. 5. Wellness office changed to be operable with only one action and without tight pinching to operate. 6. Physical therapy office changed to be operable with only one action and without tight pinching to operate.	
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 staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 3 of 9 smoke compartments. The findings were: 1. Observation on 09/22/15 from 9:40 AM to	K 038	7. Doors to the secured unit will have contractor evaluation to determine cost effective manner to allow egress without special knowledge. **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. All residents and staff have the potential to be affected by egress doors that do not open without special knowledge.	

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K 038	Continued From page 2 12:15 PM revealed door locks that required special knowledge or effort for operation from the egress side. When locked, doors in the following locations required more than one releasing operation. CNA classroom, EVS supervisor office, transportation office, clean storage on the maintenance corridor, wellness office, and the physical therapy office. At the time of the observations the Facility Maintenance Manager acknowledged the locks on the doors were more than one action. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4 2. Observation of the doors to the secured unit on 09/22/15 at 12:15 PM revealed that the doors required special knowledge to access the exit from the unsecured side by a key pad located adjacent to the door on the egress side. At the time of the observation the Facility Maintenance Manager acknowledged the door required special knowledge to access the exit from the unsecured side. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.1	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 and without tight pinching to operate **K038 continued** 3.Revise leadership rounds to include door handle inspection. 4. Install hardware to ensure egress door to MSU is able to be opened without special knowledge **Outcome:** 100% of doors in facility will have one action locking mechanism 100% egress doors will be accessible without special knowledge. Plant operations 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.	
K 143 SS=D	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;	K 143		

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K 143	Continued From page 3 (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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide qualified personnel who are familiar with the precautions necessary to avoid hazards of transfilling liquid oxygen. The findings were: Observation of a Certified Nursing Assistant on 09/22/15 at 11:15 AM revealed the staff member filling a liquid portable device without any protected equipment being utilized. Further observation revealed that all necessary protective equipment was located within the filling location. Interview with the staff member at the time of the observation revealed they were unaware of what equipment was required to be worn during the filling process. The Facility Maintenance Manager was present at the time of the observation and acknowledged the staff member not utilizing the required protective equipment. Ref: 2000 NFPA 101, Section 19.3.2.4 1999 NFPA 99, Section 8-6.2.5.2	K 143	K143 **Correction for cited residents:** Replacement of PPE in the oxygen transfilling room (apron, gloves, mask, and ear muffs Post pictures of correct PPE utilization **Identification of other residents will occur by:** All staff have the potential to be affected by inappropriate PPE while transfilling oxygen **Systematic Changes and Monitoring:** Staff education on the appropriate PPE for transfilling oxygen 10/8/15 Annual competencies for oxygen transfilling **Outcome:** 100% of staff will wear appropriate PPE while transfilling oxygen as audited by observation DON 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.	11/22/15

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K 143	Continued From page 4 1995 CGA Pamphlet P-2.5, Section 1.3.1	K 143	K147 **Correction for cited residents:**	11/22/15
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 provide the minimum number of receptacles in patient bed locations per NFPA 99. The facility did not provide written documentation for the use of a categorical waiver for power strips. The findings were: Observation on 09/22/15 from 10:15 AM to 1:00 PM revealed power strips being utilized in patient bed locations. The following rooms utilized power strips to power patient care equipment, and non-patient care equipment on the same power strip. Room #302-1, #305-2, #309-2, #310-2, #312-1, #510, and #505-2 not permitted by the categorical waiver. At the time of the observations the Facility Maintenance Manager acknowledged the use of the power strips to power patient care and non-patient care equipment on the same outlet. 1999 NFPA 99, Section 3-3.2.1.2 (d)(2)	K 147	Room 302-1, 305-2, 309-2, 310-2, 312-1, 510 and 505-2 Separate medical equipment plug in devices from non- medical equipment plug in devices Identify locations in rooms where additional electrical plug in devices are needed **Identification of other residents will occur by:** All residents have the potential to be affected by inappropriate electrical outlet usage **Systematic Changes and Monitoring:** Audit all rooms to identify the issues related to surge protectors and medical equipment Staff education on usage of electrical outlets and medical equipment Categorical waiver letter on file and to be presented to any surveyors upon entrance for survey Designate medical equipment electrical plug in devices in rooms **Outcome:** 100% of medical equipment will be on designated electrical plug in device Plant Operations 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 reported	