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 _____	05/10/2011

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 this 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 (NFPA). The facility was a fully sprinkled three story building of Type V (111) and Type II (111) construction with plan approval in 1965 and 1987. The building was equipped with a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility had a capacity of 150 certified Medicare and Medicaid beds with a census of 108 residents.	K 000		
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, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 8 smoke barrier double doors were smoke resistant. The findings were:	K 027	06/26/11 **K 027 Smoke barrier double doors gap greater than 1/8 inch and astralgal removal** Pioneer Manor will ensure door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1 ¾ inch thick solid bonded wood core. This will be accomplished by: • New astralgal installed and door adjusted to allow no more than 1/8 inch gap • All residents are equally affected by fire prevention and life safety guidelines. • Monthly preventive maintenance regarding smoke barrier doors in place and computerized reports and work orders generated Systemic Processes • Computerized log monthly preventive maintenance regarding smoke barrier doors in place • Inclusion of door inspections on a dashboard to monitor compliance with life safety guidelines Outcome: 100% of doors meet life safety guidelines regarding closure and 1/8 inch closure 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 monthly to Environment of Care committee and QA committee quarterly	

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

Administrator 6-3-11

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.

FOR ACCEPTANCE W/ RMK BJORDAHL, WHA, ON 6/13/11 JUN 06 2011

Office of Healthcare Licensing and Surveys

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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 027	Continued From page 1 Observation of the 300 hall smoke barrier double doors near the dining room on 5/10/11 at 8:43 AM showed the gap between the meeting edges of the doors was greater than 1/8-inch. The maintenance director confirmed the gap measured 1/4-inch. Further review showed screw holes ran the length of one door where an astragal (metal plate) had previously been installed. At the time of observation the maintenance director reported he was aware of the maximum gap allowed between double doors. He also confirmed an astragal had been removed but, he was not sure why or when it had been removed.	K 027	**K 029 Automatic fire extinguishing system** Pioneer Manor will ensure 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 area permitted. 19.3.2.1 This will be accomplished by: • Door latching system repaired and hardware adjustment • All areas in the facility have the potential for penetrations and door closure issues. Systemic processes • Dock door added to monthly preventive maintenance schedule Outcome: 100% of doors meet life safety guidelines regarding closure and 1/8 inch closure Plant operations staff will complete monthly inspection of all fire barriers, hazardous locations and door closures in building utilizing preventive maintenance software program Data will be reviewed monthly Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	05/12/11
K 029 SS=E	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 staff interview the facility failed to ensure hazardous area corridor doors were smoke resistant in 1 of 10 smoke compartments. The findings were: Observation of the loading dock on 5/10/11 at	K 029		

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K 029	Continued From page 2 10:56 AM showed the corridor door was equipped with an automatic closing device. With three separate attempts, observation showed the closing device did not fully latch the door into it's frame. At the time of observation the maintenance director confirmed the door would not latch when the automatic closure was activated. Furthermore, he reported corridor doors were inspected on a monthly basis. He stated he did not know why the door would not latch into the door frame.	K 029	**K 050 Fire drills** Pioneer Manor will ensure 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 9PM and 6AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This will be accomplished by: • Just in time training for all staff at that moment working regarding appropriate response to fire drill May 11, 2010 • All residents have the potential to be affected by Life safety standards Systemic Processes • Revision of fire drill review sheet to include sending completed form with any issues identified to department head for resolution June 26, 2011 • Staff education regarding fire drill expectations and policy **K 050 continued**	06/26/11
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 staff members were familiar with emergency procedures on 1 of 3 shifts. The findings were: Observation of the fire drill on 4/10/11 showed the maintenance director placed a red flashing light symbolic of a "fire" in resident room #521. At 2:19 PM two certified nurses assistants (CNA's) and a license practical nurse (LPN) entered room #521, where the "fire" was located. They removed the	K 050		

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K 050	Continued From page 3 resident and walked back to the nurses' station to ask another CNA what they should do next. After getting the instruction they walked back to the "fire" room accompanied by another CNA. At 2:22 PM the last CNA announced the "code red" in room #521 and closed the corridor door. The rest of the drill was executed quickly and per the facility's fire policy. After the drill the first two CNA's reported they were not sure of the fire drill policy. They stated they had been employed since December 2010.	K 050	**K 050 continued** • 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 • Annual mandatory fire drill training for all staff Outcome: 100% of staff will respond appropriately to fire drills Plant operations staff will conduct fire drills per schedule and policy and complete reports regarding staff response Data will be reviewed in the monthly Environment of Care meeting and any discrepancies will be individually addressed. Report to QA committee quarterly	
K 062 SS=E	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 sprinklers were unobstructed and failed to ensure sprinkler were not corroded in 2 of 10 smoke compartments. The findings were: 1. Observation of the sprinkler system on 5/10/11 between 8 AM and 11 AM showed the sprinklers in the wing 5 corridor near the chapel, wing 5A bathing room, and wing 5 janitors' closet near the dining room were obstructed. The sprinklers were installed within 12 inches of ceiling mounted lights and the bottom of the lights were below the bottom of the sprinklers' deflectors. At 8:19 AM the maintenance director reported he was aware of the spacing requirement. He further reported	K 062		

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K 050	Continued From page 3 resident and walked back to the nurses' station to ask another CNA what they should do next. After getting the instruction they walked back to the "fire" room accompanied by another CNA. At 2:22 PM the last CNA announced the "code red" in room #521 and closed the corridor door. The rest of the drill was executed quickly and per the facility's fire policy. After the drill the first two CNA's reported they were not sure of the fire drill policy. They stated they had been employed since December 2010.	K 050	**K 062 Automatic sprinkler system maintenance** Pioneer Manor will ensure 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 will be accomplished by: • Wing 5 corridor near the chapel, wing 5A bathing room and Wing 5 janitor's closet near the dining room were obstructed. Sprinkler heads in above locations will be lowered to code specs. Rapid Fire called and work order placed May 31, 2011 . Completion date June 3, 2011 • Dish room sprinkler heads showed two heads corroded. Sprinkler heads to be replaced. Rapid Fire called and work order placed May 31, 2011 . Completion date June 3, 2011 • All residents have the potential to be affected by Life safety standards Systemic Process • At least 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 • Revision of safety coach checklist to include sprinkler heads 06/02/11 • Staff education regarding CMS standards/Life Safety codes related to sprinkler heads, ceiling storage and PM expectations.	06/26/11
K 062 SS=E	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 sprinklers were unobstructed and failed to ensure sprinkler were not corroded in 2 of 10 smoke compartments. The findings were: 1. Observation of the sprinkler system on 5/10/11 between 8 AM and 11 AM showed the sprinklers in the wing 5 corridor near the chapel, wing 5A bathing room, and wing 5 janitors' closet near the dining room were obstructed. The sprinklers were installed within 12 inches of ceiling mounted lights and the bottom of the lights were below the bottom of the sprinklers' deflectors. At 8:19 AM the maintenance director reported he was aware of the spacing requirement. He further reported	K 062		

B

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K 062	Continued From page 4 that the system was inspected annually by an outside contractor, and they had not noted any obstructed sprinklers on their last report. 2. Observation of the dish room sprinkler heads on 5/10/11 at 10:26 AM showed two heads were corroded. At the time of observation the maintenance director stated he did not know how the heads had been missed during the last annual sprinkler inspection.	K 062	**K 062 continued** Outcome: 100% of sprinkler heads will be unobstructed Plant Operations/Safety coach will complete PM inspection per life safety code standard. Evaluation: • Data will be reviewed in the monthly Environment of Care meeting and any discrepancies will be individually addressed. Dashboard to reflect Environment of Care measures. Report to QA committee quarterly	
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure curtains were flame	K 074		

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K 062	Continued From page 4 that the system was inspected annually by an outside contractor, and they had not noted any obstructed sprinklers on their last report. 2. Observation of the dish room sprinkler heads on 5/10/11 at 10:26 AM showed two heads were corroded. At the time of observation the maintenance director stated he did not know how the heads had been missed during the last annual sprinkler inspection.	K 062	06/26/11 **K074 Flame Retardant fabrics** Pioneer Manor will ensure 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. This will be accomplished by: • Curtains covering Bingo machine was taken down and sent out for repairs. Curtains returned after repairs and treated with flame retardant solution and labeled. Round disk on back of curtains with a date to insure flame retardant solution is present on curtains. Documentation of flame retardant treatment in Housekeeping. • All residents are equally affected by fire prevention and life safety guidelines. Systemic Processes • Daily checklist for Environmental staff to check for all fabrics and furniture flame retardant • Revise admission packet to include statement regarding flame retardant materials/need to treat cloth, furniture or mattresses brought into facility • Staff education regarding completion of inventory list Outcome: 100% materials, furniture, mattresses will have labeling indicating flame retardant materials Data will be reviewed in the monthly Environment of Care meeting and any discrepancies will be individually addressed. Dashboard to reflect Environment of Care measures. Report to QA committee quarterly	
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure curtains were flame	K 074		

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K 074	Continued From page 5 retardant in 1 of 10 smoke compartments. The findings were: Observation of the two curtains covering the bingo board in the main dining room on 5/10/11 at 8:48 AM showed they measured 4 feet high and 12 feet long. Further review showed flame retardant documentation was not attached to the curtains. At 11:12 AM the housekeeping supervisor reported the facility treated fabric curtains with a flame retardant solution. Review of the flame retardant documentation manual showed the aforementioned curtains were not identified as having been treated. The housekeeping supervisor verified there were no other records to review.	K 074		
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 electrical junction boxes were provided with covers in 1 of 10 smoke compartments. The findings were: Observation of the electrical system above the ceiling tile in the wing 5 dining room on 5/10/11 at 1:32 PM showed an electrical junction box did not have a cover. Further review showed four electrical wires were running through the open space instead of through the knock out holes, thus preventing the cover from being installed. At the time of observation the maintenance director reported he was aware junction boxes required	K 147	**K 147 Electrical wiring and equipment** Pioneer Manor will ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2. This will be accomplished by • Wing 5 dining room electrical junction box wires rerouted through appropriate conduit and connections to include cover on junction box. June 3, 2011	06/26/11

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K 147	Continued From page 6 covers. He stated he did not know why or when the cover had been removed.	K 147	**K 147 continued** • All residents have the potential to be affected by the Life Safety Code Standards. Systemic processes • Preventive maintenance for fire doors to include junction boxes and penetrations • Implement ICRA process for all plant operations construction/above ceiling permits and penetrations • Staff education regarding work order computer system Outcome: 100% reported deficiencies to Plant ops will be corrected Plant ops to report to Environment of Care Committee monthly and QA committee quarterly, project progress, outstanding deficiencies and action plan.	