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 _____	01/29/2008

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) construction built in 1965 and 1987. The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze branch and fire alarm system.	K 000	POC ACCEPTED W/ CAVEATS GIVEN. NFPA, DD 3/10/08.	
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridor walls were smoke	K 017	K 017 The facility will ensure that corridors are separated from use areas by walls with at least ½ hour fire resistant rating. In sprinklered buildings, walls are only required to resist the passage of smoke. This will be accomplished by: 1. This standard is not met in 1 of 11 smoke barrier walls checked. On Neighborhood 2, near room 209 two unsealed wall penetrations were observed. The penetrations were the result of recent work completed in the area. Specific plan of correction is to seal the penetrations, which has already been completed and to continue our quarterly surveillance rounds of smoke barriers to ensure that all penetrations are sealed. Correction is complete as of 2/4/08.	2/4/08

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

Glenn K. Cooley — Administrator — 2/22/08

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 017	Continued From page 1 resistant in 1 of 11 smoke compartments. The findings were: Observation on 1/29/08 at 10:10 AM revealed the corridor wall near resident room #209 had two unsealed wall penetrations one half inch in diameter. Maintenance staff reported at that time the egress doors to the Alzheimer's unit had been moved 15 feet down the hall and the holes were a result of removing the doors. The doors had been moved two weeks earlier.	K 017		
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 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 resist the	K 018	K 018 The facility will ensure that doors protecting corridor openings, exits or hazardous areas are constructed of 1 ¾ inch solid-bonded core wood. There is no impediment to closing of the doors. Doors are provided with a means suitable for keeping the door closed. This will be accomplished by: 1. The facility failed to ensure corridor doors resist the passage of smoke in 1 of 11 smoke compartments. The door to resident room #315 would not latch into the frame. Maintenance staff has repaired this door and it now latches into the frame meeting required codes. The facility will ensure that all doors latch as required and the facility will continue quarterly surveillance rounds to ensure that all doors close and latch as required. Correction complete 2/4/08	2/4/08

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K 018	Continued From page 2 passage of smoke in 1 of 11 smoke compartments. The findings were: Observation on 1/29/08 at 11:09 AM revealed the corridor door to resident room #315 would not latch into the frame even with excessive force. Interview with maintenance staff at that time revealed all doors were checked on a quarterly basis.	K 018		
K 027 SS=D	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 16 smoke barrier doors latched into the frame. The findings were: Observation on 1/29/08 at 11:20 AM revealed one of the smoke barrier doors near resident room #518 did not latch into the frame. Maintenance staff reported at that time that all smoke barrier doors were inspected monthly.	K 027	K 027 The facility will ensure that door openings in smoke barriers have at least a 20-minute fire protection rating. Doors are self-closing or automatic closing. This will be accomplished by: 1. Standard was not met as evidenced by the smoke barrier door near room 518 did not latch into the frame. Maintenance staff has corrected this deficiency so the door latches as required. The facility will continue quarterly surveillance rounds to ensure that all doors close and latch as required. Correction complete 2/4/08	2/4/08
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	K 029		

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K 029	Continued From page 3 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 to ensure hazardous areas were separated from other spaces by smoke resistant partitions in 2 of 11 smoke compartments. The findings were: 1. Observation on 1/29/08 at 9:40 AM revealed the clean linen storeroom near resident room was larger than 50 square feet, had two shelves of stored towels and the corridor door was not equipped with a self-closing device. Maintenance staff reported at that time that the room had recently been converted from a sink room to a linen storeroom. 2. Observation on 1/29/08 at 12:20 PM revealed the arm had been removed from the self-closing device attached to the corridor door to storeroom B4. 3. Observation on 1/29/08 at 12:33 PM revealed the self-closing device attached to the corridor door to the activity storeroom was not able to latch the door into the frame with 3 attempts.	K 029	K 029 The facility will ensure that one hour fire rated construction (with ¾ hour fire-rated doors) protects hazardous areas. Doors are self-closing. This will be accomplished by: 1) Clean linen storage near a resident room was larger than 50 SF and was not equipped with a closure. A closure will be installed by 2/29/08. 2) Storeroom B4 had closure arm removed. Closure arm will be reinstalled on door closure by 2/29/08. 3) The self-closing device on the door to activity room was not able to latch the door in 3 attempts. The door will be adjusted by Maintenance staff to ensure that it will close as required by code. The facility Maintenance staff will continue quarterly surveillance on smoke doors to ensure they latch correctly. Completion date is 2/29/08	2/29/08
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=D	Continued From page 4 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 ensure the corridor system was unobstructed in 1 of 11 smoke compartments. The findings were: Observation on 1/29/08 between 11 AM and 1 PM revealed a clean linen cart and a soft drink machine were stored in the corridor near the chapel reducing the corridor width to less than the required 8 feet. Interview with nursing staff at 1 PM revealed the linen cart was typically stored in that location.	K 038	K 038 The facility will ensure that Exit access is arranged so that exits are readily accessible at all times. This will be accomplished by: 1. Standard not met as evidenced by a linen cart and a soft drink machine were stored in the corridor near the chapel reducing the corridor width to less than the required 8 feet. The linen cart and the soft drink machine will be relocated by 2/29/08 to areas that will not block or hinder egress at exits. All-staff will be trained on keeping hallways and exits clear during department staff meetings and/or at All-staff meetings by 3/16/08.	3/16/08
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	K 050	K 050 The facility will ensure that Fire Drills are held at unexpected times and 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 to competent personnel who are qualified to exercise leadership. This will be accomplished by: Standard not met as evidenced by: 1. Observation of fire drill on 1/29 revealed that two staff (CNA's) did not recognize that the flashing light located in the "fire" room was the "fire". Also, three lifts	

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K 050	Continued From page 5 facility staff were not familiar with emergency procedures under varying conditions. The findings were: 1. Observation of the fire drill on 1/29/08 at 2:57 PM revealed the two certified nursing assistants (CNA) that entered the "fire" room turned off the nurse call light and moved on to the next room. Maintenance staff had to show the CNAs the flashing fire/light and that it indicated a fire was in the room, he also had to tell them to activate the fire alarm system. During the drill 3 Hoyer lifts were left in the corridor of the smoke compartment were the "fire" was located. 2. Interview with the CNA's on 1/29/08 at 3:10 PM revealed they had not been taught the fire/light was used to indicate a fire.	K 050	Continued from page 5 of 10 were left in the corridor of the smoke compartment. Corrective action included immediate training for the two staff members involved regarding the use of the "fire/light" during drills and their correct actions upon locating this apparatus. All new staff hired from this point forward will receive first day training in regard to the fire alarm system and appropriate actions when they locate a fire or the fire alarm sounds. All-staff will be re-trained on the use of the "FIRE/ light" through department staff meetings in the next 30 days and at All-staff meetings conducted over then next two months. Staff will also be re-trained on the need to clear all corridors of equipment whenever there is a fire alarm. Completed by 3/16/08	3/16/08
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 sprinkler heads were properly maintained in 2 of 11 smoke compartments. The findings were: 1. Observation on 1/29/08 between 10 AM and 11 AM revealed the following locations had sprinkler heads with signs of corrosion: a. One sprinkler head in the shower room near resident room #211.	K 062	K 062 The facility will ensure that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. This will be accomplished by: Standard not met as evidenced by 1. Sprinkler heads in following locations show signs of corrosion: a) Shower room by resident room #211 b) Three heads in dishwashing room	

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K 062	Continued From page 6 b. Three heads in the dish washing room. 2. Observation on 1/29/08 between 11:30 AM and 12 PM revealed the following locations had sprinkler heads maintained less than the allowed 1 inch from the ceiling: a. The sprinkler in the corridor near resident room #503. b. One of two sprinkler heads in resident room #502. c. The sprinkler head in the ambulance entrance vestibule.	K 062	Continued from page 6 of 10 2. Sprinkler heads maintained less than the allowed 1" from the ceiling. a) Sprinkler head near resident room #503 b) 1 of 2 sprinkler heads in resident room #502 c) Sprinkler head in ambulance entrance vestibule Specific plan of correction is to have fire sprinkler contractor called in to repair/replace corroded heads and correct all clearance issues as identified and to complete a surveillance of the entire system. Completed by 3/16/08	3/16/08
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to projibit the use of portable space heaters in 1 of 11 smoke compartments. The findings were: Observation on 1/29/08 at 9:46 AM revealed a portable space heater was being used in the beauty shop. Interview at that time revealed maintenance staff was unaware the heater had been used.	K 070	K 070 The facility will ensure that portable space heaters, which are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. This will be accomplished by: 1. Standard not met as evidenced by portable space heater being used in the beauty shop. The beauty shop operator is contracted and did not know that a portable heater could not be utilized. 2. The space heater was removed on 1/31. All staff will be re-trained pertaining to the regulations associated with portable space heaters in that they are not allowed in any health care setting. Training to be completed by 3/16/08.	3/16/08
K 074 SS=D	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	K 074		

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K 074	Continued From page 7 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 window curtains were flame retardant in 1 of 11 smoke compartments. The findings were: Observation on 1/29/08 at 1:45 PM revealed the four window curtain in the level 2 lounge did not have any flame retardant documentation attached to them. Maintenance staff confirmed at that time that the curtains were not flame retardant.	K 074	K 074 The facility will ensure that 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. This will be accomplished by: #2 1. Standard not met as evidenced by 4 sets of curtains in the level lounge did not have flame retardant documentation attached to them. 2. The four window curtains will be removed and dispose of them. Environmental Services department will procure new curtains or furnish curtains that are flame retardant and have proof of fire retardant standard. All future procurement will include a requirement for flame spread rating information on material and all procurements will meet code requirements. Completed by 3/16/08	3/16/08
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130		

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K 130	Continued From page 8 Based on observation and staff interview the facility failed to ensure alcohol based hand rubs (ABHR) dispensers were properly mounted in 4 of 11 smoke compartments. The findings were: 1. Observation on 1/29/08 between 10:30 AM and 12 PM revealed the following locations had ABHR dispensers installed over ignition sources: a. The dispenser near the central elevator on the main floor was installed over a wander guard key pad. b. A dispenser was installed over an electrical receptacle in resident room #309. c. A dispenser was installed over the light switch in resident room #507. d. A dispenser was installed over the light switch in resident room #506. 2. Interview with maintenance staff on 1/29/08 at 10:42 AM revealed he was unaware ABHR dispensers could not be installed over ignition sources.	K 130	K 130 The facility will ensure that alcohol based hand rubs (ABHR) are mounted properly in all smoke compartments. This will be accomplished by: 1. Standard not met as evidenced by: a) The dispenser near the central elevator on main floor was installed over a recently placed wander guard key pad b) A dispenser was installed over an electrical receptacle in resident room #309 c) A dispenser was installed over the light switch in resident room #507 d) A dispenser was installed over the light switch in resident room #506 e) Maintenance staff did not know ABHR could not be mounted over ignition sources. Corrective action taken: 1. All dispensers cited in K 130 have been relocated to not be mounted over ignition sources. 2. Staff has been in-serviced on the location restrictions on mounting ABHR. Facility will ensure that all ABHR locations are code compliant through the Preventive Maintenance surveillance process. Completed by 2/25/08.	2/25/08
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 flexible wiring did not replace permanent fixed wiring in 4 of 11 smoke compartments. The findings were: 1. Observation on 1/29/08 between 9:30 AM and 3 PM revealed the following locations had temporary wiring replacing permanent wiring: a. The television set in resident room #113	K 147		

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K 147	Continued From page 9 was plugged into an extension cord. b. The television set in resident room #114 was plugged into an extension cord. c. The radio in the shower room near resident room #211 was plugged into a 3-way adapter. d. The television set in resident room #410 was plugged into two surge protector in- line. e. The computer at the receptionists desk was plugged into a surge protector which was plugged into a 4-way adapter. 2. Interview with maintenance staff on 1/29/08 at 9:42 AM revealed the electrical system was inspected semi-annually.	K 147	K 147 The facility will ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. This will be accomplished by: 1. Standard is not met as evidenced by the facility not ensuring that temporary flexible wiring did not replace permanent fixed wiring in 4 of 11 smoke compartments: a) The television set in resident room #113 was plugged into an extension cord b) The television set in resident room #114 was plugged into an extension cord c) The radio in shower room near resident room #211 was plugged into a 3-way adapter d) The television set in resident room #410 was plugged into two surge protectors in-line e) The computer at the receptionist's desk was plugged into a surge protector which was plugged into a 4-way adaptor Corrective action as follows: 1. Facility maintenance staff to remove surge protectors beyond 1 length, remove all four way adaptors and remove all extension cords. 2. Continuous surveillance by means of the Preventive Maintenance system already in place will be used to remove all improper use of extension cords and adaptors.	

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K 147	Continued From page 9 was plugged into an extension cord. b. The television set in resident room #114 was plugged into an extension cord. c. The radio in the shower room near resident room #211 was plugged into a 3-way adapter. d. The television set in resident room #410 was plugged into two surge protector in- line. e. The computer at the receptionists desk was plugged into a surge protector which was plugged into a 4-way adapter. 2. Interview with maintenance staff on 1/29/08 at 9:42 AM revealed the electrical system was inspected semi-annually.	K 147	Continued from page 10 of 10 3. Family members will be notified through the monthly newsletter and at resident/family forums that extension cords cannot be utilized and if they have a need to plug in equipment they can contact the maintenance department or administration to provide them with proper equipment. Completed by 3/16/08.	3/16/08