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 _____	05/04/2010

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) construction built in 1965 and 1987. 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.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 3 fire barriers were fire rated. The findings were: Observation on 5/04/10 at 11:07 AM showed the second floor fire barrier near the apartments had two unsealed cable penetrations. The largest gap was 1/2 inch wide. At the time of observation the maintenance director reported that he was aware fire barriers were required to be rated and to be	K 011	K011 **K 011 - If the building has a common wall with a nonconforming building the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for addition. Communicating openings occur only in corridors and are protected by approved self closing doors.** • Second floor barrier near apartment had two unsealed cable penetrations. Penetrations sealed with fire caulk 05/05/10 by Plant ops staff. Work order 99192925 • All residents have the potential to be affected due to ongoing technical and electrical wiring revision.	6/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Erik Bjordahl — TITLE: Administrator — (X6) DATE: 5/28/10

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.

FOC ACCEPTED W/ ERIK BJORDAHL, NHA, ON 6/09/10. JUN 01 2010

Office of Healthcare Licensing and Surveys

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 _____	05/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

6/09/10

(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) construction built in 1965 and 1987. 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.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 3 fire barriers were fire rated. The findings were: Observation on 5/04/10 at 11:07 AM showed the second floor fire barrier near the apartments had two unsealed cable penetrations. The largest gap was 1/2 inch wide. At the time of observation the maintenance director reported that he was aware fire barriers were required to be rated and to be	K 011	K011 Continued from page 1. • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Policy to be developed regarding penetrations and fire barriers to include above ceiling permit, frequency of monitoring and preventive maintenance Jun 20, 2010 • Scan all documents related to contractor handbook and permits June 20, 2010	

[redacted] TITLE (X6) DATE

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 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) construction built in 1965 and 1987. 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.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 3 fire barriers were fire rated. The findings were: Observation on 5/04/10 at 11:07 AM showed the second floor fire barrier near the apartments had two unsealed cable penetrations. The largest gap was 1/2 inch wide. At the time of observation the maintenance director reported that he was aware fire barriers were required to be rated and to be	K 011	K011 Continued from page 1. Outcome: 100% contracts will have an above ceiling permit used by contractors Methodology: Plant operations staff will complete PM inspection of all fire barriers in building. Evaluation: Report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 • Numerator: # of PM inspections completed Denominator: # of inspections due • Numerator: # of outstanding deficiencies Denominator: # of deficiencies reported	

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

[redacted]

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.

C

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 _____	05/04/2010

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K 011	Continued From page 1 continuous from floor to ceiling. He further reported that the fire barriers were inspected on a random cycle.	K 011	K011 Continued from page 1. • Numerator: # of above ceiling permits Denominator: # of contractor services	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ceilings were continuous and free of holes in 1 of 10 smoke compartments. The findings were: Observation on 5/03/10 at 5:29 PM showed the ceiling above the air handling duct in the transportation office had one unsealed conduit penetration. The hole was 4 inches square. The maintenance director reported that he was aware that ceilings were required to be continuous. He further reported that room inspection occurred randomly on a semi-annual basis. He also reported the hole had been in place for nearly one year. He could not explain why the hole had not been repaired.	K 012	K012 **K 012 Building construction type and height** • Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 • Ceiling above air handling duct in the transportation office had one unsealed conduit. Conduit penetrations sealed with fire caulk 05/05/10 by plant ops staff work order 99192888 • All residents have the potential to be affected due to ongoing technical and electrical wiring revision.	6/20/10
K 018 SS=E	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	K 018		

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K 011	Continued From page 1 continuous from floor to ceiling. He further reported that the fire barriers were inspected on a random cycle.	K 011		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ceilings were continuous and free of holes in 1 of 10 smoke compartments. The findings were: Observation on 5/03/10 at 5:29 PM showed the ceiling above the air handling duct in the transportation office had one unsealed conduit penetration. The hole was 4 inches square. The maintenance director reported that he was aware that ceilings were required to be continuous. He further reported that room inspection occurred randomly on a semi-annual basis. He also reported the hole had been in place for nearly one year. He could not explain why the hole had not been repaired.	K 012	K012 Continued from page 2. • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Policy to be developed regarding penetrations and fire barriers to include above ceiling permit, frequency of monitoring and preventive maintenance Jun 20, 2010 • Develop PM for checking fire penetrations June 20, 2010 Methodology: Plant operations staff will complete PM inspection of all fire barriers in building.	
K 018 SS=E	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	K 018		

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K 011	Continued From page 1 continuous from floor to ceiling. He further reported that the fire barriers were inspected on a random cycle.	K 011		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ceilings were continuous and free of holes in 1 of 10 smoke compartments. The findings were: Observation on 5/03/10 at 5:29 PM showed the ceiling above the air handling duct in the transportation office had one unsealed conduit penetration. The hole was 4 inches square. The maintenance director reported that he was aware that ceilings were required to be continuous. He further reported that room inspection occurred randomly on a semi-annual basis. He also reported the hole had been in place for nearly one year. He could not explain why the hole had not been repaired.	K 012	K012 Continued from page 2. Evaluation: Report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 • Numerator: # of PM inspections completed Denominator: # of inspections due • Numerator: # of outstanding deficiencies Denominator: # of deficiencies reported • Numerator: # of above ceiling permits Denominator: # of contractor services	
K 018 SS=E	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	K 018	K018 **K018 Corridor doors** • Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ inch solid-bonded core wood, or capable of resisting fire for at	6/20/10

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K 018	Continued From page 2 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 had functional latching devices in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 between 9 AM and 10 AM showed the door handles to room #517, #516 and #511 required excessive force to release. At 9:05 AM the maintenance director reported he was aware of the latching force requirement of 15 foot pounds (lbf) to release the latch. He further reported corridor doors were only inspected for proper operation annually.	K 018	K018 Continued from page 2. 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. Roller latches are prohibited. What corrective actions have been put in place for resident(s)? • Room #517,#516,#511 required excessive force to release o The above door latches repaired to prevent excessive force in opening to reflect 15 foot pounds to release June 20, 2010 o Work order 99192927	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025		

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K 018	Continued From page 2 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 had functional latching devices in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 between 9 AM and 10 AM showed the door handles to room #517, #516 and #511 required excessive force to release. At 9:05 AM the maintenance director reported he was aware of the latching force requirement of 15 foot pounds (lbf) to release the latch. He further reported corridor doors were only inspected for proper operation annually.	K 018	K018 Continued from page 2. • All residents on Neighborhood 5 have the potential to be affected , See below actions • Development of PM inspection all door handles in Pioneer Manor to meet 15 pound release requirement June 20,2010 • Preventive maintenance schedule, for door handles and door openings to ensure meeting requirement June 20,2010 • Development/revision of policy related to Preventive maintenance June 20, 2010 • Prioritization of replacement on N5 to be based on initial inspection done June 20, 2010	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025		

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PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

6/09/10

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K 018	Continued From page 2 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 had functional latching devices in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 between 9 AM and 10 AM showed the door handles to room #517, #516 and #511 required excessive force to release. At 9:05 AM the maintenance director reported he was aware of the latching force requirement of 15 foot pounds (lbf) to release the latch. He further reported corridor doors were only inspected for proper operation annually.	K 018	K018 Continued from page 2. Outcome: 100% of door latches will meet Life safety code standard Methodology: Plant operations staff will complete PM inspection of all door latches in building utilizing PM checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010. Evaluation: • Numerator: # of preventive maintenance completed on door handles • Denominator: # of door handles PM due • Numerator: # of outstanding deficiencies • Denominator: # of deficiencies	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct	K 025	K025 **K 025 Smoke barriers** Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames.	6/20/10

C

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K 025	Continued From page 3 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were: Observation on 5/04/10 between 11 AM and 11:30 AM showed the smoke barrier walls near resident room #520 and near the chapel had unsealed cable penetrations. The walls were equipped with 1-1/2 inch diameter pass through tubes. The tubes were not filled with a flame retardant material to ensure smoke resistance. At 11:05 AM the maintenance director reported he was aware that smoke barrier walls were supposed to be smoke resistant. He further reported that the walls were only randomly inspected.	K 025	K025 Continued from page 3. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4. SMOKE BARRIER NOTE • Resident room #520 and Chapel had unsealed cable penetrations, tubes not filled with a flame retardant material o Cable penetrations sealed with fire caulk, 05/05/10 by plant ops staff • All residents have the potential to be affected due to ongoing technical and electrical wiring revision.	
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	K 029		

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K 025	Continued From page 3 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were: Observation on 5/04/10 between 11 AM and 11:30 AM showed the smoke barrier walls near resident room #520 and near the chapel had unsealed cable penetrations. The walls were equipped with 1-1/2 inch diameter pass through tubes. The tubes were not filled with a flame retardant material to ensure smoke resistance. At 11:05 AM the maintenance director reported he was aware that smoke barrier walls were supposed to be smoke resistant. He further reported that the walls were only randomly inspected.	K 025	K025 Continued from page 3. • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Policy to be developed regarding penetrations and fire barriers to include above ceiling permit, frequency of monitoring and preventive maintenance Jun 20, 2010 • Develop PM checklist for checking fire penetrations June 20, 2010	
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	K 029		

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	535022	A. BUILDING 01 B. WING _____	05/04/2010

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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(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 025	Continued From page 3 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were: Observation on 5/04/10 between 11 AM and 11:30 AM showed the smoke barrier walls near resident room #520 and near the chapel had unsealed cable penetrations. The walls were equipped with 1-1/2 inch diameter pass through tubes. The tubes were not filled with a flame retardant material to ensure smoke resistance. At 11:05 AM the maintenance director reported he was aware that smoke barrier walls were supposed to be smoke resistant. He further reported that the walls were only randomly inspected.	K 025	K025 Continued from page 3. Outcome: 100% contracts will have an above ceiling permit used by contractors 100% PM checklist will be completed and deficiencies identified Methodology: Plant operations staff will complete semiannual inspection of all fire barriers in building utilizing audit checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 • Numerator: # of PM inspections completed Denominator: # of inspections due • Numerator: # of outstanding deficiencies Denominator: # of deficiencies reported	
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	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 025	Continued From page 3 penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 of 8 smoke barrier walls were smoke resistant. The findings were; Observation on 5/04/10 between 11 AM and 11:30 AM showed the smoke barrier walls near resident room #520 and near the chapel had unsealed cable penetrations. The walls were equipped with 1-1/2 inch diameter pass through tubes. The tubes were not filled with a flame retardant material to ensure smoke resistance. At 11:05 AM the maintenance director reported he was aware that smoke barrier walls were supposed to be smoke resistant. He further reported that the walls were only randomly inspected.	K 025	K025 Continued from page 3. • Numerator: # of above ceiling permits Denominator: # of contractor services	
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	K 029	K029 **K 029 Automatic fire extinguishing system** • 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	6/20/10

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 2 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 5:05 PM showed the loading dock walls had two unsealed pipe penetrations. The largest gap was 2 inches wide. At the time of observation the maintenance director reported he was aware of the smoke resistance requirement. He further reported the area was inspected semi-annually. He was unable to explain why the holes had not been sealed. 2. Observation on 5/03/10 at 5:19 PM showed the the hot water furnace room had a 16 inch by 24 inch hole in the ceiling. At the time of observation the maintenance director reported the hole was created three weeks prior due to water damage. He further reported that the leak had been fixed and the sheet rock was now dry. He stated he did not know why the hole had not been fixed. 3. Observation on 5/03/10 at 5:49 PM showed the second floor nursing storeroom corridor door was equipped with an automatic closing device. The arm had been removed and the set screw replaced in the actuation arm. At the time of observation the maintenance director reported hazardous areas were inspected on a random basis.	K 029	K029 Continued from page 4. 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 • Loading dock walls had two unsealed pipe penetrations o Penetration sealed with fire caulk by plant ops staff 05/20/2010 • Hot furnace room had a 16 inch by 24 inch hole in ceiling due to leak o Hole in ceiling repaired by plant ops staff 05/05/10 • Second floor nursing storeroom corridor with automatic closing device had arm removed and set screw replaced. o Door closure device repaired by plant ops staff 05/05/10	
K 036 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Travel distance (exit access) to exits are in accordance with 7.6. 19.2.5.10	K 036		

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 2 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 5:05 PM showed the loading dock walls had two unsealed pipe penetrations. The largest gap was 2 inches wide. At the time of observation the maintenance director reported he was aware of the smoke resistance requirement. He further reported the area was inspected semi-annually. He was unable to explain why the holes had not been sealed. 2. Observation on 5/03/10 at 5:19 PM showed the the hot water furnace room had a 16 inch by 24 inch hole in the ceiling. At the time of observation the maintenance director reported the hole was created three weeks prior due to water damage. He further reported that the leak had been fixed and the sheet rock was now dry. He stated he did not know why the hole had not been fixed. 3. Observation on 5/03/10 at 5:49 PM showed the second floor nursing storeroom corridor door was equipped with an automatic closing device. The arm had been removed and the set screw replaced in the actuation arm. At the time of observation the maintenance director reported hazardous areas were inspected on a random basis.	K 029	K029 Continued from page 4. • All areas in the facility have the potential for penetrations and door closure issues. Preventive maintenance program to be developed June 20, 2010 • Above ceiling permit developed and will be utilized by all contractors June 20, 2010 • Policy to be developed regarding penetrations, door closures and fire barriers to include above ceiling permit, frequency of monitoring and preventive maintenance Jun 20, 2010 • Develop PM checklist for checking fire penetrations, hazardous locations and June 20, 2010 • Staff education regarding PM inspections expectations June 20, 2010	
K 036 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Travel distance (exit access) to exits are in accordance with 7.6. 19.2.5.10	K 036		

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 2 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 5:05 PM showed the loading dock walls had two unsealed pipe penetrations. The largest gap was 2 inches wide. At the time of observation the maintenance director reported he was aware of the smoke resistance requirement. He further reported the area was inspected semi-annually. He was unable to explain why the holes had not been sealed. 2. Observation on 5/03/10 at 5:19 PM showed the the hot water furnace room had a 16 inch by 24 inch hole in the ceiling. At the time of observation the maintenance director reported the hole was created three weeks prior due to water damage. He further reported that the leak had been fixed and the sheet rock was now dry. He stated he did not know why the hole had not been fixed. 3. Observation on 5/03/10 at 5:49 PM showed the second floor nursing storeroom corridor door was equipped with an automatic closing device. The arm had been removed and the set screw replaced in the actuation arm. At the time of observation the maintenance director reported hazardous areas were inspected on a random basis.	K 029	K029 Continued from page 4. Outcome: 100% of contractors will have completed above ceiling permit 100% of PM are done per schedule Methodology: Plant operations staff will complete semiannual inspection of all fire barriers, hazardous locations and door closures in building utilizing audit checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 • 100% contracts will have an above ceiling permit used by contractors • Numerator: # of PMinspections completed Denominator: # of inspections due • Numerator: # of outstanding deficiencies Denominator: # of deficiencies reported • Numerator: # of above ceiling permits Denominator: # of contractor services	
K 036 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Travel distance (exit access) to exits are in accordance with 7.6. 19.2.5.10	K 036	K036 **K 036 Exit Access** Travel distance (exit access) to exits are in accordance with 7.6. 19.2.5.10	6/20/10

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K 036	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure travel distances did not exceed 150 feet in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign. The egress travel distance was measured by maintenance staff and reported to be more than the allowed 150 feet. The total distance from the stairwell door through the 300 hall and to the front entrance was 268 feet. This total distance would be divided in half if the stairwell door could be used as an egress exit. At the time of observation the maintenance director reported the door was marked with a "no exit" sign and locked because resident were trying to leave through the door. He further reported that he was unaware of the maximum travel distance requirement.	K 036	K036 Continued from page 5. • Stairwell door marked with "no exit" door o Second door handle lock will be removed as well as the "No Exit" sign removed. Exit sign will be posted. June 20, 2010 • All egress doors will be in accordance with Life Safety standards • Staff education regarding PM inspections expectations June 20, 2010 • Attach alarm system to door to alarm when door opened June 20, 2010	
K 038 SS=E	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 ensure 1 of 11 exit access doors was accessible at all times. The findings were:	K 038		

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K 036	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure travel distances did not exceed 150 feet in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign. The egress travel distance was measured by maintenance staff and reported to be more than the allowed 150 feet. The total distance from the stairwell door through the 300 hall and to the front entrance was 268 feet. This total distance would be divided in half if the stairwell door could be used as an egress exit. At the time of observation the maintenance director reported the door was marked with a "no exit" sign and locked because resident were trying to leave through the door. He further reported that he was unaware of the maximum travel distance requirement.	K 036	K036 Continued from page 5. • Policy development to include preventive maintenance activities of doorways, signage, penetrations, life safety systems, door closures etc June 20, 2010. Outcome: 100% of doors will have appropriate signage Methodology: Plant operations staff will complete PM inspection of all egress distance, door closures in building utilizing PM checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 Evaluation: • Numerator: # of PM inspections completed Denominator: # of inspections due	
K 038 SS=E	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 ensure 1 of 11 exit access doors was accessible at all times. The findings were:	K 038		

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K 036	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure travel distances did not exceed 150 feet in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign. The egress travel distance was measured by maintenance staff and reported to be more than the allowed 150 feet. The total distance from the stairwell door through the 300 hall and to the front entrance was 268 feet. This total distance would be divided in half if the stairwell door could be used as an egress exit. At the time of observation the maintenance director reported the door was marked with a "no exit" sign and locked because resident were trying to leave through the door. He further reported that he was unaware of the maximum travel distance requirement.	K 036	K036 Continued from page 5. • Numerator: # of doors appropriately labeled and egress within standard distance Denominator: # of inspections	
K 038 SS=E	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 ensure 1 of 11 exit access doors was accessible at all times. The findings were:	K 038	K038 **K 038 Exit access arrangement** • Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 o Second floor door handle lock will be removed as well as the "No Exit" sign removed. Exit sign will be posted. June 20, 2010	6/20/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 038	Continued From page 6 Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign and locked with a push button lock. The lock did not release with the activation of the fire alarm system or loss of electrical power. At the time of observation the maintenance director reported the door was locked because residents were trying to leave the building through that door. He further reported that he was aware that required egress doors could not be locked.	K 038	K038 Continued from page 6. • All egress doors will remain unlocked to allow egress • Staff education regarding PM inspections expectations June 20, 2010 • Attach alarm system to door to alarm when door opened June 20, 2010	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency battery lights were properly tested for 4 of the past 12 months. The findings were: 1. Review of the emergency battery light testing records showed the 30 second monthly test had not been done during January, February, March and April in 2010. On 5/03/10 at 5:05 PM the maintenance assistant reported he was unaware that the test was supposed to be a 30-second test. He further reported that he had conducted the test each month, but not for more than ten seconds at a time. In addition, the maintenance assistant stated the testing had not been documented. 2. Review of the emergency battery light testing records showed the 90 minute annual test had	K 046		

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K 038	Continued From page 6 Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign and locked with a push button lock. The lock did not release with the activation of the fire alarm system or loss of electrical power. At the time of observation the maintenance director reported the door was locked because residents were trying to leave the building through that door. He further reported that he was aware that required egress doors could not be locked.	K 038	K038 Continued from page 6. • Policy development to include preventive maintenance activities of doorways, signage, penetrations, life safety systems, door closures etc June 20, 2010 Outcome: 100% of doors will have appropriate signage	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency battery lights were properly tested for 4 of the past 12 months. The findings were: 1. Review of the emergency battery light testing records showed the 30 second monthly test had not been done during January, February, March and April in 2010. On 5/03/10 at 5:05 PM the maintenance assistant reported he was unaware that the test was supposed to be a 30-second test. He further reported that he had conducted the test each month, but not for more than ten seconds at a time. In addition, the maintenance assistant stated the testing had not been documented. 2. Review of the emergency battery light testing records showed the 90 minute annual test had	K 046		

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K 038	Continued From page 6 Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign and locked with a push button lock. The lock did not release with the activation of the fire alarm system or loss of electrical power. At the time of observation the maintenance director reported the door was locked because residents were trying to leave the building through that door. He further reported that he was aware that required egress doors could not be locked.	K 038	K038 Continued from page 6. Methodology: Plant operations staff will complete PM inspection of all egress distance, door closures in building utilizing PM checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency battery lights were properly tested for 4 of the past 12 months. The findings were: 1. Review of the emergency battery light testing records showed the 30 second monthly test had not been done during January, February, March and April in 2010. On 5/03/10 at 5:05 PM the maintenance assistant reported he was unaware that the test was supposed to be a 30-second test. He further reported that he had conducted the test each month, but not for more than ten seconds at a time. In addition, the maintenance assistant stated the testing had not been documented. 2. Review of the emergency battery light testing records showed the 90 minute annual test had	K 046		

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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 038	Continued From page 6 Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign and locked with a push button lock. The lock did not release with the activation of the fire alarm system or loss of electrical power. At the time of observation the maintenance director reported the door was locked because residents were trying to leave the building through that door. He further reported that he was aware that required egress doors could not be locked.	K 038	K038 Continued from page 6. Evaluation: • Numerator: # of semi annual inspections completed Denominator: # of inspections due • Numerator: # of doors appropriately labeled and egress within standard distance Denominator: # of inspections	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency battery lights were properly tested for 4 of the past 12 months. The findings were: 1. Review of the emergency battery light testing records showed the 30 second monthly test had not been done during January, February, March and April in 2010. On 5/03/10 at 5:05 PM the maintenance assistant reported he was unaware that the test was supposed to be a 30-second test. He further reported that he had conducted the test each month, but not for more than ten seconds at a time. In addition, the maintenance assistant stated the testing had not been documented. 2. Review of the emergency battery light testing records showed the 90 minute annual test had	K 046	K046 **K 046 Emergency lighting** • Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1 • Immediate change in policy to reflect 30 second testing of emergency lighting • 30 second test on emergency lighting by Plant ops staff 05/05/10 • Work order 99192880 • All residents have the potential to be affected and revision in policy ensures appropriate testing of emergency lighting. • Monthly 30 second tests on the emergency lighting pack immediately completed 05/05/10	6/20/10

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6/09/10

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K 038	Continued From page 6 Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was marked with a "no exit" sign and locked with a push button lock. The lock did not release with the activation of the fire alarm system or loss of electrical power. At the time of observation the maintenance director reported the door was locked because residents were trying to leave the building through that door. He further reported that he was aware that required egress doors could not be locked.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency battery lights were properly tested for 4 of the past 12 months. The findings were: 1. Review of the emergency battery light testing records showed the 30 second monthly test had not been done during January, February, March and April in 2010. On 5/03/10 at 5:05 PM the maintenance assistant reported he was unaware that the test was supposed to be a 30-second test. He further reported that he had conducted the test each month, but not for more than ten seconds at a time. In addition, the maintenance assistant stated the testing had not been documented. 2. Review of the emergency battery light testing records showed the 90 minute annual test had	K 046	K046 Continued from page 7. • Policy revision regarding emergency lighting testing and preventive maintenance to include monthly 30 second testing and annual 90 minute testing. June 20,2010 • Staff education regarding emergency lighting testing June 20,2010 Outcome: 100% of emergency lighting will be tested according to Life Safety Code Methodology: Plant Operations will complete PM inspection and complete emergency lighting per life safety code standard. Report will be given semiannually to QA committee and Safety committee with discrepancies evaluated and investigated.	

E

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K 046	Continued From page 7 not been done within the last year. The test was last performed on 4/15/2009. On 5/03/10 at 5:05 PM the maintenance director stated he was unaware that the test was last completed in April 2009. He also stated he was not currently planning on performing the test.	K 046	K046 Continued from page 7. • Numerator: # of monthly emergency lighting tests completed Denominator: # of tests due • Numerator: # of outstanding deficiencies Denominator: # of deficiencies	
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit signs were properly placed in 2 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 5:12 PM showed the second floor glass door leading to the inner courtyard was not marked with a "no exit" sign. As a result the door could be confused as an exit by visitor not familiar with the exit pathways. At the time of observation the maintenance director reported he was not aware that doors that may be confused as exits needed to be signed with "no exit" signs. 2. Observation on 5/04/10 at 8:26 AM showed the door leading to the stairwell near the first floor chapel was marked with a "no exit" sign. At the time of observation the maintenance director reported the door was marked as "no exit" and locked because residents were trying to leave the building through this door. He stated he was	K 047	K047 **K 047 Exit and directional signs** • Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 • Door way not marked into courtyard o "Not An Exit sign developed and put on door by Plant Ops staff 05/05/10 • Door marked with "No Exit" sign o Second floor door handle lock will be removed as well as the "No Exit" sign removed. Exit sign will be posted. June 20, 2010 • Door marked for visitor and resident visual cue	6/20/10

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K 046	Continued From page 7 not been done within the last year. The test was last performed on 4/15/2009. On 5/03/10 at 5:05 PM the maintenance director stated he was unaware that the test was last completed in April 2009. He also stated he was not currently planning on performing the test.	K 046		
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure exit signs were properly placed in 2 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 5:12 PM showed the second floor glass door leading to the inner courtyard was not marked with a "no exit" sign. As a result the door could be confused as an exit by visitor not familiar with the exit pathways. At the time of observation the maintenance director reported he was not aware that doors that may be confused as exits needed to be signed with "no exit" signs. 2. Observation on 5/04/10 at 8:26 AM showed the door leading to the stairwell near the first floor chapel was marked with a "no exit" sign. At the time of observation the maintenance director reported the door was marked as "no exit" and locked because residents were trying to leave the building through this door. He stated he was	K 047	K047 Continued from page 8. • Annual inspection of all doors for appropriate signage June 20,2010 and annually thereafter • Staff education regarding, PM inspections expectations June 20, 2010 • Policy development to include annual, semiannual and preventive maintenance activities of doorways, signage, penetrations, life safety systems, door closures etc Outcome: 100% of doors will have appropriate signage Methodology: Plant operations staff will complete PM inspection of all egress distance, door closures in building utilizing PM checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 .	

B

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K 047	Continued From page 8 aware that required exits were to be designated with "exit" signs.	K 047	K047 Continued from page 8. Evaluation: • Numerator: # of PM inspections completed	
K 050 SS=F	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 record review and staff interview the facility failed to ensure fire drills were held on each shift during each quarter for 2 of the past 4 quarters. Review of the fire drill testing records showed a drill had not been conducted on the third shift during the second quarter of 2009. Further review showed a drill had not been conducted on the second shift during the fourth quarter of 2009. On 5/03/10 at 5:05 PM the maintenance director confirmed the above mentioned drills had been missed, and no other records were available for review.	K 050	K050 Denominator: # of inspections due **K 050 Fire drills** • 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 • Fire drills will be done per schedule at least quarterly on each shift • Fire drills will be performed at least quarterly on each shift per schedule regardless who is assigned preventive maintenance	6/20/10
K 052 SS=F	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	K 052		

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K 047	Continued From page 8 aware that required exits were to be designated with "exit" signs.	K 047		
K 050 SS=F	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 record review and staff interview the facility failed to ensure fire drills were held on each shift during each quarter for 2 of the past 4 quarters. Review of the fire drill testing records showed a drill had not been conducted on the third shift during the second quarter of 2009. Further review showed a drill had not been conducted on the second shift during the fourth quarter of 2009. On 5/03/10 at 5:05 PM the maintenance director confirmed the above mentioned drills had been missed, and no other records were available for review.	K 050	K050 Continued from page 9. • Staff education regarding fire drill expectations and policy June 20, 2010 • Policy review regarding fire drill scheduling May 5,2010 Outcome: 100% fire drills will be done per PM schedule and Life Safety Code Standards Methodology: Plant operations staff will conduct fire drills per schedule and policy Evaluation: Report to Safety committee and QA committee semiannually (June and Dec) first report due by June 20, 2010 • Numerator: # of fire drill completed at least quarterly on each shift • Denominator: # of fire drills scheduled	
K 052 SS=F	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	K 052	K052 **K 052 Fire alarm system maintenance** • A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72.	6/20/10

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K 052	Continued From page 9 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 7 fire alarm system components was properly tested. The findings were: Review of the fire alarm system testing records showed the system had not been activated on a monthly basis. The system was not activated during October and December of 2009. On 5/03/10 at 5:05 PM the maintenance director reported he was not aware the system was required to be activated on a monthly basis, and no other records were available for review.	K 052	K052 Continued from page 9. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 • Activation of fire alarm system will be completed monthly 06/01/10 • The fire alarm system will be activated monthly per schedule regardless who is assigned preventive maintenance • Staff education regarding fire alarm activation and policy June 20, 2010 • Policy review regarding fire alarm system scheduling May 5,2010	
K 056 SS=F	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	K 056		

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K 052	Continued From page 9 requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure 1 of 7 fire alarm system components was properly tested. The findings were: Review of the fire alarm system testing records showed the system had not been activated on a monthly basis. The system was not activated during October and December of 2009. On 5/03/10 at 5:05 PM the maintenance director reported he was not aware the system was required to be activated on a monthly basis, and no other records were available for review.	K 052	K052 Continued from page 9. Outcome: 100% fire drills will be done per PM schedule and Life Safety Code Standards Methodology: Plant operations staff will conduct fire drills per schedule and policy Evaluation: Report to Safety committee and QA committee semiannually (June and Dec) first report due by June 20, 2010 • Numerator: # of fire drill completed at least quarterly on each shift Denominator: # of fire drills scheduled	
K 056 SS=F	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	K 056	K056 **K 056 Automatic sprinkler system** • 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,	6/20/10

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K 056	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure exterior canopies had sprinkler coverage and the facility failed to ensure sprinkler system valves were supervised in 3 of 10 smoke compartments. The findings were: 1. Observation on 5/03/10 at 4:37 PM showed the dining room was constructed of large wood beams and wood support beams. Observation of the exterior canopies showed the West, South and East canopies were more than 48 inches wide. The canopies were 60-inches wide and they did not have sprinkler coverage. Review of previous survey reports showed the facility was originally cited for this same issue on 5/03/07 and had received a time limited waiver and an extension until 1/31/09. Telephone logs show the interim administrator was contacted on 3/18/09, and he reported the sprinkler project had been completed. The current administrator and plant operations manager were unaware of the previous survey and the need for sprinkler coverage. 2. Observation on 5/03/10 at 5:42 PM showed the canopy over the second floor locker room entrance did not have sprinkler coverage. The canopy was more than 4 feet wide. The canopy measured 14 feet long and 6 feet 6 inches wide. At the time of observation the maintenance director confirmed through inspection that the construction material was wood joists. He reported that he was not aware that wood	K 056	K056 Continued from page 11. • 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 • I wish to request a time limited waiver in regards to the installation of sprinkler system in the above mentioned areas. I wish to request extension until October 1, 2010 for completion of sprinkler installation • Continue to meet Life Safety Code Standard guidelines while waiting for installation, Capital budget request and approval anticipated July 31, 2010, submit plans for approval to state July 31, 2010, anticipated approval September 15, 2010, anticipated installation October 1, 2010. • All residents have the potential to be at risk in the event of a fire	

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K 056	Continued From page 11 canopies wider than 4 feet were required to have sprinkler coverage. 3. Review of the sprinkler system testing records showed the contractor had stated "Anti-freeze valves need chain and lock" on the 7/21/09 report. Observation of the anti-freeze valves on 5/03/10 at 6:10 PM showed the closing of the valves would prevent water flow in the event of a fire. The valves were not electronically supervised by the fire alarm system. At the time of observation the maintenance director reported he was unaware that sprinkler valves were to be supervised. Review of the State agency's plan inspection log showed the anti-freeze project was not submitted for review. 4. Observation on 5/04/10 at 10:14 AM showed the canopy over the safety unit back exit did not have sprinkler coverage. The canopy was wider than 4 feet. The canopy measured 11 feet long and 8 feet wide. At the time of observation the maintenance director confirmed the building's roof structure was constructed of wood rafters and decking.	K 056	K056 Continued from page 10. • Request time limited waiver extension. New sprinkler heads to be installed October 1, 2010 • Request for bid to Rocky Mountain fire 05/06/10 and received • Chain and lock antifreeze valves to be electronically supervised by the fire system, tamper switches installed, synchronization with fire system to be completed June 20, 2010 • All future projects will meet Life Safety Code standards related to need for State approval • Staff education regarding expectations and CMS standards related to sprinkled areas June 20,2010	
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 in 3 of 10 smoke compartments.	K 062	K062 **K 062 Automatic sprinkler system maintenance** • 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	06/20/10

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K 062	Continued From page 12 The findings were: Observation of the sprinkler system on 5/04/10 between 9 AM and 11 AM showed the sprinklers in the wing 5 nurse supervisor's office, wing 5 dining room, safety unit's laundry room, walk-in cooler, kitchen dish room and kitchen preparation area 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 9:16 AM the maintenance director reported he was aware of the spacing requirement. He further reported that the system was inspected annually by an outside contractor, and they had not noted any obstructed sprinklers on their last report.	K 062	K062 Continued from page 12. • Wing 5 nurse supervisor office, wing 5 dining room, safety units laundry room, walkin cooler, kitchen dish room and kitchen prep area had sprinkler heads obstructed. o Sprinkler heads in above locations will be lowered to code specs. Rocky Mtn Fire called 05/06/10 and work request placed. Completion date June 20, 2010	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all building and equipment modifications in 2 of 10 smoke compartments received construction plan approval in accordance with State law. The findings were: 1. Observation on 5/03/10 at 6:10 PM showed the anti-freeze sprinkler system pressure reducing valves did not have electronic supervision. Review of the State agency's plan inspection log showed the anti-freeze project had never been submitted for review and approval. At the time of observation the maintenance director reported he was aware that all modifications to the building structure or functional changes required plan	K 130		

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K 062	Continued From page 12 The findings were: Observation of the sprinkler system on 5/04/10 between 9 AM and 11 AM showed the sprinklers in the wing 5 nurse supervisor's office, wing 5 dining room, safety unit's laundry room, walk-in cooler, kitchen dish room and kitchen preparation area 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 9:16 AM the maintenance director reported he was aware of the spacing requirement. He further reported that the system was inspected annually by an outside contractor, and they had not noted any obstructed sprinklers on their last report.	K 062	K062 Continued from page 12. • All residents have the potential to be affected by Life safety standards • PM inspection by Plant Ops staff of sprinklers, obstructions, ceiling storage standards per audit tool developed June 20,2010 • Annual inspection by outside contractor with specific expectation regarding ceiling and sprinkler obstructions	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all building and equipment modifications in 2 of 10 smoke compartments received construction plan approval in accordance with State law. The findings were: 1. Observation on 5/03/10 at 6:10 PM showed the anti-freeze sprinkler system pressure reducing valves did not have electronic supervision. Review of the State agency's plan inspection log showed the anti-freeze project had never been submitted for review and approval. At the time of observation the maintenance director reported he was aware that all modifications to the building structure or functional changes required plan	K 130		

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 _____	05/04/2010

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K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all building and equipment modifications in 2 of 10 smoke compartments received construction plan approval in accordance with State law. The findings were: 1. Observation on 5/03/10 at 6:10 PM showed the anti-freeze sprinkler system pressure reducing valves did not have electronic supervision. Review of the State agency's plan inspection log showed the anti-freeze project had never been submitted for review and approval. At the time of observation the maintenance director reported he was aware that all modifications to the building structure or functional changes required plan	K 130		

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PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

6/09/10

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K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all building and equipment modifications in 2 of 10 smoke compartments received construction plan approval in accordance with State law. The findings were: 1. Observation on 5/03/10 at 6:10 PM showed the anti-freeze sprinkler system pressure reducing valves did not have electronic supervision. Review of the State agency's plan inspection log showed the anti-freeze project had never been submitted for review and approval. At the time of observation the maintenance director reported he was aware that all modifications to the building structure or functional changes required plan	K 130	K130 **K 130 Miscellaneous** This standard is not met as evidenced by: Based on observation and staff interview the facility failed to ensure all building and equipment modifications in 2 of 10 smoke compartments received construction plan approval in accordance with State law. • Future installations, remodels as directed by CMS/Life Safety code will be submitted to State for approval prior to ~~completion~~, COMMENCEMENT Current modifications letter sent to state June 20, 2010 • All residents have the potential to be affected by Life Safety Code Standards	06/20/10

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K 130	Continued From page 13 approval. 2. Observation of 5/04/10 at 9:11 AM showed a portable air conditioning unit was in operation in an alcove near resident room #517. Further review showed the unit had a flexible exhaust tube that penetrated the ceiling tile and the roof deck. The tube exhausted the hot air produced by the unit. At the time of observation the maintenance director reported the installation of the unit did not receive plan approval from the State agency as required by Wyoming law, (W.S. 35-2-906)..He could not explain why the modification had not been submitted to the State agency for plan approval. --- Based on observation and staff interview the facility failed to ensure corridors did not have dead-ends in 1 of 10 smoke compartments. The findings were: Observation on 5/04/10 at 8:20 AM showed the stairwell door near the first floor chapel was locked and marked with a "no exit" sign. At the time of observation the maintenance staff measured the distance from the exit door to the middle of the 300 hall corridor and found it was 33 feet. He further reported the door was locked because residents were trying to exit the building via the stairs.	K 130	K130 Continued from page 13. • A monitoring system for modifications to any smoke compartment will be implemented to ensure state approval of system prior to work June 20, 2010 • Policy development/revision to direct monitoring program June 20, 2010 • Staff education regarding above process June 20, 2010 Outcome: 100% of projects requiring state approval will have state approval prior to initiation of project Methodology: Project completion list to include state application and approval. Plant Operations will report to Administrative Council, or QA committee projects and state approval semiannually first report due June 20, 2010 • Numerator: # of projects approved by state Denominator: # of current projects #2 K-130 12-5-12-TD K-038.	
K 143 SS=E	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	K 143	K143 **K 143 Transferring of oxygen** Transferring of oxygen is: • separated from any portion of a facility wherein patients are	06/20/10

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K 143	Continued From page 14 fire-resistive construction; (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 ensure the volume of liquid oxygen did not exceed 341 liters (90 gallons) in 1 of 10 smoke compartments. The findings were: Observation of the liquid oxygen storeroom on 5/04/10 at 9:50 AM showed two large silver tanks and two small tanks were located in the room. The oxygen supplier confirmed the large tanks held 196 liters and the small tanks 41 liters, each. The combined volume of liquid oxygen was 474 liters. At the time of observation the maintenance director was unaware of the facility's liquid oxygen storeroom had a maximum capacity of 341 liters.	K 143	K143 Continued from page 14 housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; • in an area that is mechanically ventilated, sprinkled, and has ceramic or concrete flooring; and • 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 • One of the 196 L O2 tanks was eliminated. Total liter O2 currently 278 liters • All residents have the potential to be affected by Life Safety Code Standards • Signage to be placed in oxygen storage areas regarding maximum storage capacity June 20, 2010	
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	K 147		

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K 143	Continued From page 14 fire-resistive construction; (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 ensure the volume of liquid oxygen did not exceed 341 liters (90 gallons) in 1 of 10 smoke compartments. The findings were: Observation of the liquid oxygen storeroom on 5/04/10 at 9:50 AM showed two large silver tanks and two small tanks were located in the room. The oxygen supplier confirmed the large tanks held 196 liters and the small tanks 41 liters, each. The combined volume of liquid oxygen was 474 liters. At the time of observation the maintenance director was unaware of the facility's liquid oxygen storeroom had a maximum capacity of 341 liters.	K 143	K143 Continued from page 14 • Staff education regarding oxygen storage requirements June 20, 2010 • Policy review and revision regarding oxygen storage and signage June 20, 2010 Outcome: 100% of the time oxygen storage volume capacity will be in accordance with Life Safety Code Standard Methodology: Plant operations staff will complete semiannual inspection of all oxygen storage areas utilizing PM checklist and report to Safety committee and QA committee semiannually (June and Dec) first inspection due by June 20, 2010 • Numerator: # deficiencies outstanding Denominator: # of inspections due	
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	K 147	K147 **K 147 Electrical wiring and equipment** • Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	06/20/10

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K 147	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure damaged electrical equipment was replaced in 1 of 10 smoke compartments. The findings were: Observation of room #510 on 5/04/10 at 9:23 AM showed the electrical receptacle near the head of the bed was damaged. The receptacle was charred on both sides of the two blade ports. At the time of observation the maintenance director reported he was aware that damaged electrical equipment must be replaced. He further reported the electrical system was only inspected semi-annually. He could not explain why the receptacle had not been noticed by nursing or housekeeping staff and brought to the attention of the maintenance department.	K 147	K147 Continued from page 15. • Room 510: Electrical outlet replaced 05/05/10 • All residents have the potential to be affected by the Life Safety Code Standards. • Safety coach to review all electrical outlets for deficiencies and report to Plant ops staff any issue • Staff education regarding environmental safety 05/05/10 • Development of weekly safety sweep for staff at Pioneer Manor June 20, 2010 Outcome: 100% deficiencies identified will be reported to Plant ops and work order generated Methodology: Weekly safety sweep submitted to Quality with follow-up on deficiencies. Plant ops to report to QA committee outstanding deficiencies and action plan. Safety coach to report to Safety coach meeting and leadership safety coach audits. Evaluation; • Numerator: # of deficiencies outstanding • Denominator: # of deficiencies reported	