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

PRINTED: 04/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

(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 single story building of Type V (000) construction built in 1970 and 1990. The building was equipped with a specialty domestic wet sprinkler system in the file store room, the laundry and the oxygen transferring room only. The rest of the building is not protected by an automatic supervised sprinkler system. A fire alarm system is installed in all corridors and commons areas along with single station battery operated smoke detectors in every resident room. K-017 and K-056 can be obviated by the Fire Safety Evaluation System (FSES). If the facility agrees to the conditions of the FSES they can write an "F" in the Providers Plan of Correction column and an "F" in the Completion Date column to accept the FSES. If the facility wants to fix the deficiency they can fill in the Providers Plan of Correction column with the appropriate information and dates.	K 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by this provides of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary. RECEIVED Wyoming Dept of Health JUN 08 2010 Office of Healthcare Licensing and Surveys	
K 017 SS=F	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	K 017	K 017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Walter Randall — TITLE: Administrator — (X6) DATE: 4/30/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
Wyoming Dept of Health
APR 30 2010
Office of Healthcare Licensing and Surveys

Revised/Approved & Changes on Pgs 3 and 4 after fax & Administrator on 6/4/10 @ 3:48P — SL

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1801 HOWELL AVENUE WORLAND, WY 82401

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K 017	Continued From page 1 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 extended from the floor to the roof deck above in 3 of 6 smoke compartments. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed the corridor walls on halls #1, #2, #3 and #4 stopped above the ceiling tile. Interview with the administrator on 4/7/10 at 2:10 PM confirmed no construction was done on the corridor walls during the previous year. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items or placing an "F" in the Provider's Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 017		
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	K 018	K 018 The facility will ensure corridor doors are resistant to the passage of smoke in smoke compartments This will be accomplished by:	

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K 018	Continued From page 2 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 were resistant to the passage of smoke in 3 of 6 smoke compartments. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed corridor doors to resident rooms #202, #210, #302, #305 and #401 did not close completely in their frames unless force in excess of 5 foot pounds of pressure was applied. Interview with the administrator at that time confirmed the doors did not seat in their frames and needed adjusting.	K 018	a. Striker plates will be adjusted so less than five foot pounds of pressure used to close door. b. Doors will be planed so doors will sit in frame. Monitoring: Director of Maintenance or designee will monitor doors monthly. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring monthly at QA meeting for review and suggestions.	5/23/10 5/23/10 Resident Rooms 202, 210, 302, 305, 401
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029	K 029 The facility will ensure a hazardous area door will close in a smoke compartment. This will be accomplished by:	

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K 029	Continued From page 3 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a hazardous area was separated from patient use areas in 1 of 6 smoke compartments. The findings were: Observation on 4/7/10 between 1:10 PM revealed the door to the laundry room did not close in its frame after three tries. The door had a self-closure attached. However, interview with the facility administrator at that time confirmed the self-closure did not seat the door in its frame.	K 029	to the laundry Room The door will be planed off on the latch side so the self-closure will sit the door in its frame. This was done on 04/12/10. Monitoring: Director of Maintenance or designee will monitor doors monthly. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring monthly at QA meeting for review and suggestions.	5/23/10
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 three emergency exit signs were fully illuminated. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed 1 of 2 burned out light bulbs in each of the following emergency exit signs: a. The sign at the nurse's station between	K 047	K 047 The facility will ensure that exit signs are properly illuminated. This will be accomplished by: The burned out bulbs were replaced on 04/07/10 in the emergency exit signs at: a. nurses station between hallways 100 and 200 — 5/23/10 b. main entrance — 5/23/10 c. dining room — 5/23/10 Monitoring: Director of Maintenance or designee will	

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K 047	Continued From page 4 hallways one and two, b. The main entrance exit sign c. The exterior exit sign in the dining room. d. Interview with the facility administrator at that time confirmed the exit signs identified above had burned out light bulbs and needed to be replaced.	K 047	monitor monthly. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring monthly at QA meeting for review and suggestions.	
K 052 SS=D	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 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 28 smoke detectors was installed correctly and the fire alarm system was tested during 3 of the previous 12 months in accordance with the provisions of NFPA 72. The findings were: Review of testing records on 4/7/10 at 3:48 PM revealed the fire alarm system was not tested during the months of May 2009, February 2010 and March 2010. In addition, observation on 4/7/10 at 12:48 PM revealed smoke detector (#7) in the special care unit had dropped down approximately 1 inch from the ceiling. The facility administrator confirmed the above observation	K 052		

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K 047	Continued From page 4 hallways one and two, b. The main entrance exit sign c. The exterior exit sign in the dining room. d. Interview with the facility administrator at that time confirmed the exit signs identified above had burned out light bulbs and needed to be replaced.	K 047		
K 052 SS=D	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 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 28 smoke detectors was installed correctly and the fire alarm system was tested during 3 of the previous 12 months in accordance with the provisions of NFPA 72. The findings were: Review of testing records on 4/7/10 at 3:48 PM revealed the fire alarm system was not tested during the months of May 2009, February 2010 and March 2010. In addition, observation on 4/7/10 at 12:48 PM revealed smoke detector (#7) in the special care unit had dropped down approximately 1 inch from the ceiling. The facility administrator confirmed the above observation	K 052	K 052 The facility will ensure that the fire alarm system will be tested monthly and smoke detectors will be correctly installed. This will be accomplished by: a. The fire alarm system will be tested monthly by the Director of Maintenance or his designee and recorded in the maintenance log book. Western States Fire Protection tested the system on 04/12/10 and the results will be put in the maintenance log when received. b. Smoke detector #7 in special care unit was flush mounted with ceiling on 04/27/10. Monitoring: Director of Maintenance or designee will monitor and test monthly and results will be recorded in the Maintenance Log. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report	5/23/10 5/23/10

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K 052	Continued From page 5 and also stated the maintenance manager was unavailable during the above three months cited.	K 052	results of monitoring monthly at QA meeting for review and suggestions.	
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 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to ensure 6 of 6 smoke compartments were fully sprinkled. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed the building was primarily constructed of a Type II (111) construction, but several areas were observed to have wood construction making the building a Type V (000) structure. The building did not have a complete supervised automatic complete sprinkler system as required by the Code for type V buildings. The facility did have a domestic wet sprinkler system in the file store room, the laundry, and the oxygen transferring room. Interview with the administrator on 4/7/10 at 2:10 PM confirmed a	K 056	K 056 F	

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K 056	Continued From page 6 complete sprinkler system had not been installed during the previous year. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items, or placing an "F" in the Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 056		
K 062 SS=F	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 record review and staff interview the facility failed to ensure the domestic fire sprinkler system was tested during two of the previous four quarters. The findings were: Review of the domestic fire sprinkler system testing records revealed the water flow and supervisory signal devices had not been tested during the fourth quarter of 2009 or the first quarter of 2010. Further review revealed testing records were present in the facility maintenance log in the July 2009 section however, these records were not dated or signed. Interview with the facility administrator at that time confirmed the maintenance manager responsible for conducting the tests was unavailable during the above stated times.	K 062	K 062 The facility will ensure the domestic fire sprinkler system is tested quarterly. This will be accomplished by: The 2010 second quarter Water Flow and Supervisory Signal Devices were tested on 04/21/10 by Western States Fire Protection Company. The results will be logged when receive. Monitoring: Director of Maintenance or designee will monitor and test quarterly and results will be recorded in the Maintenance Log. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring quarterly at QA meeting for review and suggestions.	5/23/10
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064		

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K 056	Continued From page 6 complete sprinkler system had not been installed during the previous year. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items, or placing an "F" in the Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 056		
K 062 SS=F	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 record review and staff interview the facility failed to ensure the domestic fire sprinkler system was tested during two of the previous four quarters. The findings were: Review of the domestic fire sprinkler system testing records revealed the water flow and supervisory signal devices had not been tested during the fourth quarter of 2009 or the first quarter of 2010. Further review revealed testing records were present in the facility maintenance log in the July 2009 section however, these records were not dated or signed. Interview with the facility administrator at that time confirmed the maintenance manager responsible for conducting the tests was unavailable during the above stated times.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all	K 064	K 064 The facility will ensure the thirteen dry	

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K 064	Continued From page 7 health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based upon record review and staff interview the facility failed to test 13 of 13 portable fire extinguishers during 1 of the previous 12 months in accordance with NFPA 10 Section 4-4.3 & Table 5-2. The findings were: Review of facility maintenance records on 4/7/10 at 3:48 PM revealed 13 of 13 dry chemical portable fire extinguishers (ABC type) located throughout the facility were not inspected during the month of May 2009. Interview with the administrator at the time of the observation confirmed the maintenance manager responsible for conducting the inspections was unavailable during the month of May.	K 064	chemical portable fire extinguishers (ABC type) will be inspected monthly. This will be accomplished by: The director of maintenance will monitor, inspect, and record in maintenance log the findings of the monthly inspection of fire extinguishers. Monitoring: Director of Maintenance or designee will monitor and inspect monthly and findings will be recorded in the Maintenance Log. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring monthly at QA meeting for review and suggestions.	5/23/10
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the	K 144	K 144 The facility will ensure the emergency generator will be inspected weekly and exercised under load for thirty minutes per month. This will be accomplished by: The director of maintenance of his designee will inspect weekly and exercise the generator under load for thirty minutes per month. The findings will be recorded in the maintenance log.	5/23/10

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K 144	Continued From page 8 facility failed to ensure the emergency generator was tested during 3 of the previous 12 months. The findings were: Review of facility emergency generator testing records on 4/7/10 at 3:48 PM revealed the facility did not test the generator during the months of May 2009, February 2010, and March 2010. Interview with the administrator confirmed the maintenance manager responsible for testing the generator was unavailable during those three months.	K 144	The April check was done by Kapps Electric on 04/22/10. Monitoring: Director of Maintenance or designee will monitor monthly and record findings in the maintenance log. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance will report results of monitoring monthly at QA meeting for review and suggestions.	
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 compliance with the National Electric Code by maintaining the required 3 feet of work space in front of electrical panels in 2 of 6 smoke compartments. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed shelving material was stacked in front of and blocked access to an electrical panel in the clean laundry room. In addition, cleaning supplies were stored in front of and blocked access to an electrical panel in the soiled utility room in the 100 hallway. Interview with the administrator at the time of the observations confirmed the electrical panels were blocked. Based on observation and staff interview the facility failed to ensure electrical wiring was in	K 147		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

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K 144	Continued From page 8 facility failed to ensure the emergency generator was tested during 3 of the previous 12 months. The findings were: Review of facility emergency generator testing records on 4/7/10 at 3:48 PM revealed the facility did not test the generator during the months of May 2009, February 2010, and March 2010. Interview with the administrator confirmed the maintenance manager responsible for testing the generator was unavailable during those three months.	K 144		
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 compliance with the National Electric Code by maintaining the required 3 feet of work space in front of electrical panels in 2 of 6 smoke compartments. The findings were: Observation on 4/7/10 between 11:30 AM and 2:10 PM revealed shelving material was stacked in front of and blocked access to an electrical panel in the clean laundry room. In addition, cleaning supplies were stored in front of and blocked access to an electrical panel in the soiled utility room in the 100 hallway. Interview with the administrator at the time of the observations confirmed the electrical panels were blocked. Based on observation and staff interview the facility failed to ensure electrical wiring was in	K 147	K 147 The facility will ensure electric wiring is in compliance with National Electric code. This will be accomplished by: 1. Red tape will be placed on floor to mark the required three feet of work space in front of the electrical panel in clean laundry room and soiled utility room. A sign will be placed on wall "Not to place any object within the red lines." 2. The wall mounted electrical outlet located over the sink in the linen room will be replaced with a ground fault circuit interrupt and contracted out to Kapps Electric for completion. 3. The outlets in two medication rooms will be placed on the emergency circuit and the cover	5/23/10 5/23/10 5/23/10

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

(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 147	Continued From page 9 compliance with the National Electric Code in 1 of 6 smoke compartments. The findings were: Observation on 4/7/10 at 12:30 PM revealed one-wall mounted electrical outlet was not ground fault circuit interrupt (GFCI) protected against water exposure. The outlet was located over the counter approximately four feet from the sink in the linen room in the connecting corridor. Interview with the administrator at the time confirmed the above observation. Based on observation and staff interview, the facility failed to maintain and identify separate essential electric circuits in two of two medical storage rooms in accordance with NFPA Section 3-4.2.2.2. The findings were: Observation on 4/7/10 at 1:33 PM revealed the medication refrigerators in both the medication storage rooms in the 100/200 hallway and the 300/400 hallway were plugged into outlets with white cover plates. Neither plate was red or labeled as part of the emergency electrical branch. Interview with the facility administrator stated he did not know if the outlets were part of the emergency circuit	K 147	plates will be replaced with red ones and labeled as part of the emergency electrical branch. This work has been contracted out to Kapps Electric for completion. Monitoring: Director of Maintenance or designee will monitor numbers two and three quarterly. The Director of Housekeeping or designee will monitor number one weekly. Any issues noted will be addressed immediately. Quality of Assurance: Director of Maintenance and Director of Housekeeping will report results of their monitoring monthly at QA meeting for review and suggestions.	