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 B. WING	06/12/2013

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-012, 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.	
K 012 SS=D	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 the minimum construction	K 012	**K012** a. F b. F c. F d. F	F F F F

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

Admin | 7/3/2013

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.

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 _____	06/12/2013

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 012	Continued From page 1 requirements were met for a non-sprinkled building in 6 of 6 smoke compartments. The findings were: 1. Observation on 6/12/13 between 11:30 AM and 1:00 PM revealed the facility was primarily constructed of Type II (111) Construction. The following areas were constructed of combustible materials Type V (000) and the facility was not protected by a complete supervised automatic sprinkler system: a. The vertical smoke barrier wall above the ceiling tile in hall #2 and hall #3. b. A false wall above the ceiling tile near the janitor's closet in hall #3. c. Two cross corridor draft stop walls above the ceiling tile near the administration area. d. The sky light shaft in halls #1, #2, #3 and #4. 2. Interview with the administrator on 6/12/13 at 1:48 PM confirmed the aforementioned areas were constructed of combustible materials and the building was not equipped with a complete sprinkler system. (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 012		
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	K 017	**K017** F	F

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 _____	06/12/2013

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 017	Continued From page 2 non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor walls extended from the floor to the roof deck above in 5 of 6 smoke compartments. The findings were: Observation on 6/12/13 between 11:30 AM and 1:00 PM revealed the corridor walls on halls #1, #2, #3 and #4 stopped above the ceiling tile. Interview with the administrator on 6/12/13 at 1:48 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 Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		

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 _____	06/12/2013

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 018	Continued From page 3 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two corridor doors were resistant to the passage of smoke in 1 of 6 smoke compartments. The findings were: Observation on 6/12/13 between 11:30 AM and 1:00 PM revealed two corridor doors to resident rooms #405 and #409 did not close completely in their frames unless a force in excess of 5 foot-pounds was applied. The maintenance manager verified these findings at the times of the observations. Reference: NFPA 101, Life Safety Code, 2000	K 018	**F 018** The facility will ensure all corridor doors are resistant to the passage of smoke in 6 smoke compartments. This will be accomplished by: Facility doors will be checked on a monthly basis. Any doors that take excess force greater than 5 ft-lbs will be repaired and documented. On 6/12/13 Rooms #405 and #409 were repaired and closed properly within limits. Monitoring: Director of maintenance will monitor monthly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	8/9/13

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 _____	06/12/2013

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 018	Continued From page 4 edition, Section 19.3.6.3.2 (existing) Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5lbf is applied at the latch edge of the door.	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure smoke barrier doors at two locations were resistant to the passage of smoke in 2 of 6 smoke compartments. The findings were: Observation on 6/12/13 at 2:48 PM revealed the smoke barrier doors between the main hall - nurse ' s station 1&2 and the main hall - nurse ' s station 3&4 did not close completely during a fire drill. In both cases, one of the two doors had seals attached to the edge of the door, however the doors did not close completely because the sequence of door closure was incorrect. As a	K 027	**K 027** The facility will ensure smoke barriers at all locations to the passage of smoke in all 6 smoke compartments. This will be accomplished by: 6/13/13: Smoke barrier doors were repaired by adjusting closing speed sequence on Halls One & Two. Smoke barrier doors on Hall Three & Four were repaired to open and close without resistance. Closing speed sequence adjusted. Monitoring: Facility's smoke barrier doors will be checked weekly for proper closing and proper sealing by the Maintenance Supervisor. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	8/9/13 8/9/13

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 _____	06/12/2013

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 027	Continued From page 5 result, the seals prevented the doors from closing completely forming a tight seal. The maintenance manager confirmed the finding at the time of the observation. Reference: NFPA 101, Life Safety Code, 2000 edition. 19.3.7.6 Doors in smoke barriers shall comply with 8.3.4 and shall be self closing or automatic closing in accordance with 19.2.2.2.6. 8.3.4.1 Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be withour undercuts, louvers, or grilles.	K 027		
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 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 2 of 6 smoke compartments. The findings were: Observation on 6/12/13 between 11:30 AM and	K 029	**K 029** The facility will ensure a hazardous area is separated from patient use areas in all 6 smoke compartments. This will be accomplished by: 6/27/13: Door closure ordered for Medical Records Office. Will be installed on 7/14/13. 6/13/13: Laundry Door repaired. Monitoring. Maintenance Supervisor will check doors equipped with self-closing device weekly. Any issues notes will be addressed immediately. Quality Assurance: Director of Maintenance will report	8/9/13 8/9/13

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 _____	06/12/2013

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 029	Continued From page 6 1:00 PM revealed the following concerns. a. The door to the medical records room did not have a self closure device attached to the door. The room was greater than 50 square feet and contained several file cabinets of paper medical records. b. The door to the housekeeping/laundry room did not close in its frame after three tries. The door had a self-closing device (SCD) attached. c. The maintenance manager confirmed the finding at the time of the observations. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.2, 8.2.4.3.5 18.3.2.1 Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. 8.4.1.2 In new construction, where protection is provided with automatic extinguishing systems without fire-resistive separation, the space protected shall be enclosed with smoke partitions in accordance with 8.2.4. 8.2.4.3.5 Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. 7.2.1.8.1 Self Closing Devices. A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic closing in accordance with 7.2.1.8.2.	K 029	results of monitoring quarterly or more frequently as needed at the Quality Assurance 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	K 056	**K056** F	F

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 _____	06/12/2013

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 056	Continued From page 7 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 six of six smoke compartments were fully sprinkled. The findings were: Observation on 6/12/13 between 11:30 AM and 1:00 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 facility administrator on 6/12/13 at 1:48 PM confirmed a complete sprinkler system was currently being installed and would be completed in approximately 6 weeks. (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 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		

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	06/12/2013

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 074 SS=D	Continued From page 8 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure three wall decorations were flame retardant in 2 of 6 smoke compartments. The findings were: Observation on 6/12/13 between 11:30 PM and 1:00 PM revealed the following concerns a. A 4 ' x4 ' evergreen wreath was hanging on the wall in the dining room. b. A 2 ' x2 ' evergreen wreath was hanging on the wall in resident room #408. c. A 2 ' x2 ' evergreen wreath was hanging on the exit door from the special care unit.	K 074	**K 074** The facility will ensure that all wall decorations are flame retardant. This will be accomplished by: 6/13/13: Evergreen wreaths were removed from affected areas. Monitoring. Maintenance Supervisor will check facility areas on a weekly basis. Item concerning non-flame retardant decorations will be removed from facility. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	8/9/13

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 _____	06/12/2013

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 074	Continued From page 9 d. Interview with the maintenance staff at the time of the observations confirmed none of the wreaths were fire retandant. Reference: NFPA 101, Life Safety Code, 2000 edition. Section 10.3.1 Where required by the applicable provisions of this code, draperies, curtains and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074		
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 observation and interview, the facility failed to provide a remote system alarm at a work site that is readily observable by personnel for monitoring the emergency power supply system (EPSS). The findings were: Observation on 6/12/13 at 2:48 PM revealed the facility ' s EPSS consisted of a generator in the generator room and a transfer switch located in the boiler room. The location of the generator and	K 144	**K 144** The facility will provide a remote system alarm at a work site that is readily observable by personnel for monitoring the emergency power supply system. This will be accomplished by: Facility has contacted "Advanced Generator Technologies" to equip generator with proper remote alarm system. Bid/project will be approved prior to date of compliance. Monitoring. Maintenance Supervisor will monitor progress of project on a weekly basis. Any issues notes will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	8/9/13

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 _____	06/12/2013

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 144	Continued From page 10 transfer switch panel was not in an area continuously occupied and there was no enunciator panel installed at a location that was readily observable by staff. Interview on 6/12/13 at 2:48 PM with the maintenance manager confirmed the above observation. Reference NFPA 99, 3-4.1.1.15. A remote enunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12). Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.16(a) and (b) occur, but need not display these conditions individually.	K 144		
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	**K 211** The facility will ensure all alcohol based hand rub dispensers are not installed over an ignition source in all 6 smoke compartments. This will be accomplished by: The dispensers in rooms 113, 111, 114, & 116 were all removed. Monitoring. Maintenance Supervisor will monitor progress of project on a weekly basis. Any issues notes will be addressed	8/9/13

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 _____	06/12/2013

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 211	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure four alcohol based hand rub (ABHR) dispensers were not installed over an ignition source in 1 of 6 smoke compartments. The findings were: Observation on 6/12/13 at 12:48 PM revealed ABHR dispensers were attached to the wall directly over light switchs in resident rooms #113, #114, #116 and in the conference room #111. Interview with the maintenance manager at the time of the observation confirmed the dispensers were located over a possible ignition source. Reference: NFPA 101, Life Safety Code, 2000 edition, 19.3.2.7* Alcohol-based Hand-rub Solutions. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.4.3 unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8 m). (2) The maximum individual dispenser fluid capacity shall be: (a) 0.3 gallons (1.2 liters, 1200 cc/ml, 40 oz.) for dispensers in rooms, corridors, and areas open to corridors (b) 0.5 gallons (2.0 liters, 2000 cc/ml, 66.6 oz.) for dispensers in suites of rooms (3) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2 m) from each other. (4) Not more than an aggregate 10 gallons (37.8	K 211	immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	

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 _____	06/12/2013

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 211	Continued From page 12 liters) of alcohol-based hand rub solution shall be in use in a single smoke compartment outside of a storage cabinet. (5) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (6) The dispensers shall not be installed over or directly adjacent to an ignition source. (7) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.	K 211		