Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
535048	A. Building 01 - MAIN BUILDING 01 B. Wing	08/21/2013

Name of Facility	Street Address, City, State, Zip Code
WORLAND HEALTHCARE AND REHABILITATION CENTI	1901 HOWELL AVENUE WORLAND, WY 82401

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix FSES Reg. # NFPA 101 LSC K0012	Correction Completed 08/09/2013	ID Prefix FSES Reg. # NFPA 101 LSC K0017	Correction Completed 08/09/2013	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 08/09/2013
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 08/09/2013	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 08/09/2013	ID Prefix FSES Reg. # NFPA 101 LSC K0056	Correction Completed 08/09/2013
ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 08/09/2013	ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 08/09/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TS 8/27/13	Date:	Signature of Surveyor:	Date: 8/21/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	

Followup to Survey Completed on: 06/12/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

PRINTED: 09/04/2013
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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 B. WING	R 08/21/2013

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 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 partially sprinklered, single story building of Type II (111) and V (000) construction with plan approval in 1970 and 1990. The building was equipped with a partial automatic wet domestic sprinkler system and with a zoned fire alarm system. The facility had a capacity of 87 certified Medicare and Medicaid beds.	{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 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: 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 transfer switch panel was not in an area continuously occupied and there was not an enunciator panel installed at a location that was	{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: 1. This facility will submit plans to the Wyoming Department of Health	9/9/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

PC Modified Approved w/ Dec Corrections, Administrator, on 9/12/13

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	535048	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 08/21/2013

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

9/12/13

(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 1 readily observable by staff. Interview on 8/12/13 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. On 8/19/13 at 8:30 AM, the maintenance manager reported the generator annunciator panel and audible alarm had not been installed. He also reported the panel will not be installed until after the Wyoming Department of Health (WDH) gives approval for the installation and the contractor can schedule the job. He reported that the installation plans have not been delivered to the WDH. He was not sure when the plans will be submitted to the WDH. Reference NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition; 3-5.6.1 A remote, common audible alarm powered by the storage battery shall be provided as specified in 3-5.5.2 (d). This remote alarm shall be located outside of the EPS service room at a work site readily observable by personnel.	(K 144)	2. Plan will be reviewed and approved by Wyoming Department of Health 3. This facility will have enunciator panel installed 4. Final inspection will be completed by Wyoming Department of Health Monitoring: Maintenance Supervisor will monitor progress of project on a weekly and as needed basis until project has final inspection. 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. THE FACILITY IS REQUESTING A TIME LIMITED WAIVER UNTIL 11/22/13.	10/7/13 11/4/13 11/22/13