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

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 _____	07/07/2014

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 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single-story building of Type V (000) construction built in 1970 and 1990. The building was equipped with a supervised, automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 87 certified Medicare and Medicaid beds with a census of 59.	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 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Modified POC Accepted by Phone with Heidi Glandz (Acting Administrator) on 9/17/14 @ 11:38AM Mel Nelson 9/18/14 This STANDARD is not met as evidenced by:	K 017	**K 017** Corridors will be separated from use areas by walls constructed with at least ½ hour fire resistance rating. This will be accomplished by: The penetrations in the bathroom near the lobby, the janitor close, the soiled utility (100 wing), the facility copy room, and the staff break room have been sealed with approved fire resistive sealant. Monitoring: The Director of Maintenance will monitor for new penetrations with any type of construction that affects the six (6) smoke	9/3/14

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

[signature] — Admin — 7/30/2014

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.

R Dee Cozzens

WY Dept of Health
JUL 31 2014
Healthcare Licensing and Surveys

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K 017	Continued From page 1 Based on observation and staff interview, the facility failed to ensure walls were smoke resistant in 2 of 6 smoke compartments. The findings were Observation on 07/07/14 from 10:15 AM to 1:25 PM of the bathroom (near the lobby), the janitor closet, the soiled utility (100 wing), the facility copy room, and the staff break room revealed several penetrations in the walls. At the time of the observations, the facility administrator acknowledged the penetrations.	K 017	compartments. Any penetrations noted will be addressed and sealed immediately. Quality Assurance: Director of Maintenance will report monthly results of monitoring and new construction as needed at the Quality Assurance meeting for review and suggestions.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	**K 018** The facility will ensure that doors are smoke resistant in all six (6) smoke compartments. This will be accomplished by: 1. The roller latches were removed from the smoke barrier cross-corridor doors adjacent to rooms 109 and 110 as regulated by CMS. 9/3/14 2. The leading edge gasket of door was replaced to maintain smoke resistance. 9/3/14 Above repairs will be Mde by Maintenance Staff gs 9/17/14 Monitoring: The Director of Maintenance will monitor all fire doors weekly to assure gaskets are in proper working condition. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report	

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K 018	Continued From page 2 Based on observation and staff interview, the facility failed to ensure doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 10:50 AM of the smoke barrier cross-corridor doors adjacent to rooms 109 and 110 revealed a missing gasket on the leading edge of the door creating a non-smoke resistant condition.	K 018	monthly results of monitoring at the Quality Assurance meeting for review and suggestions.	
K 038 SS=D	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: 1) Based on observation and staff interview, the facility failed to provide doors in a means of egress equipped with an approved special locking arrangement in 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 11:14 AM of the cross-corridor doors into the secure unit located near rooms 201 and 202 revealed that the door swinging into the secure unit from the non-secure side was a required means of egress for residents not assigned to the secure unit and who did not require specialized security measures for their safety. This door was locked with a magnetic lock which was controlled by a wall-mounted keypad with the code printed on top. The door was provided with a peephole and signage	K 038	**K 038** The facility will provide doors in a means of egress equipped with an approval special locking arrangement in all six (6) smoke compartments. The exit access will be arranged so that exits are readily accessible at all times. This will be accomplished by: All Locking Mechanisms will be removed from Non-Secured side, ~~1. A "Push to Exit" will be installed onto the Secure Unit entrance doors that will interrupt the magnetic lock system.~~ 9/3/14 2. The padlock will be removed from the West gate for evacuation into courtyard. To avoid confusion a "Not An Exit" sign will be placed on North Gate. 9/3/14 Monitoring: Director of maintenance will monitor monthly. Any issues noted will be addressed immediately.	

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K 038	Continued From page 3 reading " PLEASE LOOK THRU PEEPHOLE BEFORE OPENING DOOR. " Interview with the Administrator at the time of the observation confirmed the special locking arrangement. 2) Based on observation and staff interview, the facility failed to continuously maintain the means of egress free of locking devices requiring the use of keys or special knowledge for operation under all lighting conditions in 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 11:18 AM of the means of egress through a fenced-in assembly area accessible from the secure unit revealed a gate which lead to the public way was secured with a combination padlock. The courtyard in question did not provide an adequate dispersal distance (50 ft.) away from the building for all of the occupants. Interview with the Administrator during the observation verified that the padlock was used to secure the gate. References NFPA Life Safety Code (2000) 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor.	K 038	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.	

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K 038	Continued From page 4 Doors shall be operable with not more than one releasing operation. 7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock independent of the access control system electronics and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of	K 038		

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K 038	Continued From page 5 egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No.1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No.2: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No.3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038		
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	K 052	**K 052** The facility will ensure that a Semi-annual battery load voltage test is done on the fire alarm system. This will be accomplished by: The facility will arrange for ~~[illegible]~~ A Licensed Vendor 9/3/14 ~~Gramell~~ to complete and schedule semi-annual battery load voltage test. 9/17/14 Monitoring: The facility Administrator will monitor	

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K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on review of fire alarm testing and maintenance records and staff interview, the facility failed to provide documentation identifying the required semi-annual battery load voltage testing in compliance with the requirements of NFPA 72. The findings were: Review on 07/07/14 from 2:00 PM to 2:45 PM of the fire alarm testing and maintenance records revealed the absence of one semi-annual battery load test in 2013 as required by NFPA 72-1999, Section 7-3.2 (6). At the time of the review, the Facility Maintenance Manager acknowledged the lack of documentation for the battery load test.	K 052	semi-annually to ensure compliance. Quality Assurance: Director of Maintenance will report testing results semi-annually at the Quality Assurance meeting for review and suggestions.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate storage	K 076	**K 076** The facility will ensure adequate storage requirements of nonflammable gases in all six (6) smoke compartments. This will be accomplished by: The Oxygen Room was cleaned and all combustible materials were removed on 7/29/14. by Maintenance Staff. 9/3/14 Monitoring: Director of maintenance will monitor weekly for the first quarter and then monthly. Any combustible items noted will be removed immediately.	9/3/14

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K 076	Continued From page 7 requirements of nonflammable gases per NFPA 99 in 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 1:32 PM of the Oxygen Storage room revealed combustible materials (a mop head, plastic cups, and plastic wrapping) being stored in the room. At the time of the observation, the Administrator confirmed the materials located inside the Oxygen Storage room. REFERENCES NFPA 99 (1999) Section 4-3.1.1.2 (7) Combustible materials, such as paper, cardboard, plastic, and fabrics shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide.	K 076	Quality Assurance: Director of Maintenance will report results of monitoring monthly at the Quality Assurance meeting for review and suggestions.	
K 147 SS=D	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, the facility failed to provide electrical wiring and equipment in accordance with the Life Safety Code, section 9.1.2, and NFPA 70 for 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 2:22 PM of the attic space on the 200 hallway revealed an electrical receptacle with exposed electrical wiring and the receptacle was missing a cover.	K 147	**K 147** The facility will ensure electrical wiring and equipment are in compliance in all six (6) smoke compartments. This will be accomplished by: The electrical receptacle with exposed electrical wiring and missing receptacle cover in the attic space on the 200 hallway was replaced and repaired on 07/28/2014. By Maintenance Staff. SJ 8-17-14 Monitoring: Director of maintenance will monitor monthly and as need with any electrical construction. Any issues noted will be addressed immediately.	9/3/14

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K 076	Continued From page 7 requirements of nonflammable gases per NFPA 99 in 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 1:32 PM of the Oxygen Storage room revealed combustible materials (a mop head, plastic cups, and plastic wrapping) being stored in the room. At the time of the observation, the Administrator confirmed the materials located inside the Oxygen Storage room. REFERENCES NFPA 99 (1999) Section 4-3.1.1.2 (7) Combustible materials, such as paper, cardboard, plastic, and fabrics shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide.	K 076	Quality Assurance: Director of Maintenance will report results of monitoring monthly at the Quality Assurance meeting for review and suggestions.	
K 147 SS=D	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, the facility failed to provide electrical wiring and equipment in accordance with the Life Safety Code, section 9.1.2, and NFPA 70 for 1 of 6 smoke compartments. The findings were: Observation on 07/07/14 at 2:22 PM of the attic space on the 200 hallway revealed an electrical receptacle with exposed electrical wiring and the receptacle was missing a cover.	K 147		