STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING 01 B. WING _____	08/18/2015

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 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 56.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
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.	K 018	**K018** The facility will provide a suitable means of keeping the doors closed accessing the egress corridors in 1 of 6 smoke compartments. This will be accomplished by: The Door on Room 109 was repaired on August 24, 2015 and is operating within guidelines. Repair was done by maintenance staff. Monitoring: Maintenance Supervisor will conduct bi-weekly inspections of facility doors to assure proper operations.	~~11/2015~~ 10/5/15

Modified POC DATES VIA Phone Call with Hied. Glanz Business Office Manager on 10/7/15 @ 9:23 AM

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

Administrator | 9/10/2015

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.

SEP 14 2015
Healthcare Licensing and Surveys

POC Accepted VIA Phone Call with Administrator Dee Cozzens on 9/17/15 @ 9:20 AM

34354

5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING 01 B. WING	08/18/2015

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 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a suitable means of keeping the doors closed accessing the egress corridors in 1 of 6 smoke compartments. The findings were: Observation on 08/18/15 at 9:15 AM of room #109 revealed when the door was fully closed it would not latch into the door frame. At the time of the observation the Facility Maintenance Manager acknowledged the door would not latch into it's frame. Ref: 2000 NFPA 101 Section 19.3.6.3.2	K 018	Quality Assurance: Director of Maintenance will report monthly results of monitoring to the Quality Assessment and Assurance Committee monthly for review and suggestions.	
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 hazardous areas were	K 029	K029 The facility will ensure hazardous areas are protected from the corridor with self-closing doors in 1 of 6 smoke compartments. This will be accomplished by: Penetrations of the housekeeping storage room were repaired on 9/8/15. Monitoring: Maintenance Supervisor will conduct monthly facility inspections for penetration and repair upon discovery. Quality Assurance: Director of Maintenance will report	~~11/20/15~~ 10/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING 01 B. WING _____	08/18/2015

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 2 protected from the corridor with self-closing doors in 1 of 6 smoke compartments. The findings were: Observation of the house keeping storage room on 08/18/15 at 10:06 AM revealed two 2" penetrations in the south wall. At the time of the observation the Facility Maintenance Manager acknowledged the penetrations. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	monthly results of monitoring to the Quality Assessment and Assurance Committee monthly for review and suggestions.	
K 046 SS=D	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 document review and staff interview, the facility failed to provide documentation identifying a maintenance policy of the emergency lighting system. The findings were: Document review and staff interview of the testing/maintenance documentation on 08/18/15 from 10:30 AM to 11:30 AM revealed the lack of a testing & maintenance policy for the emergency lighting system. No documentation was made available during the survey to indicate that the required 30 second monthly and 90 minute annual testing of the emergency lighting have been performed. Interview with the Facility Maintenance Manager confirmed that the required testing has not been completed.	K 046	**K046** The facility will provide documentation identifying a maintenance policy of the emergency lighting system. This will be accomplished by: Maintenance Supervisor will acquire documentation to be filled out monthly for testing of Emergency Lighting System and required yearly 90 minute test. Monitoring: Maintenance Supervisor will monitor monthly. Quality Assurance: Director of Maintenance will report monthly results of monitoring to the Quality Assessment and Assurance Committee monthly for review and suggestions.	~~11/20/15~~ 10/5/15