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

~~Office of Healthcare~~ Licensing and Surveys

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 _____	03/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL 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 provider 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=F	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	K 012	K012 The facility will ensure walls are smoke resistance in all 6 compartments. This will be accomplished by: 1. The four unsealed holes in Room #218 will be sealed/filled.	4/26/09 ~~05/01/09~~

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

Administrator 04/01/09

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.

POC ACCEPTED W/ IRENE JOHNSTON, NHA

OP 4/06/09.

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K 012	Continued From page 1 facility failed to ensure walls were smoke resistant in 1 of 6 smoke compartments. The findings were: 1. Observation on 3/10/09 at 1:49 PM revealed the wall above the resident over bed lights in resident room #218 had four unsealed 1/4 inch holes. Interview with the maintenance director at the time of observation revealed all rooms were inspected monthly. He further reported the over bed lights had recently been replaced. 2. Observation on 3/10/09 at 2:10 PM revealed the wall in the #1 and #2 hall medication room had a 1 inch unsealed hole behind the door. Interview with the maintenance director at the time of observation revealed medication rooms were not routinely inspected. Based on observation and staff interview the facility failed to ensure the minimum construction requirements were met for a non-sprinkled building in 6 of 6 smoke compartments. The findings were: 1. Observation on 3/10/09 between 3 PM and 5 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.	K 012	2. The hole in Hall 1 & 2 Med Room will be sealed/filled. The Med Room. ~~05/01/09~~ 4/22/09 1. F Monitoring: Director of maintenance will monitor/inspect all areas quarterly. 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.	F

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K 012	Continued From page 2 d. The sky light shaft in halls #1, #2, #3 and #4. 2. Interview with the administrator on 3/10/09 at 5 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 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 the facility failed to ensure	K 017	K017 F	F

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K 017	Continued From page 3 corridor walls extended from the floor to the roof deck above in 5 of 6 smoke compartments. The findings were: Observation on 3/10/09 between 3 PM and 6 PM revealed the corridor walls on halls #1, #2, #3 and #4 stopped above the ceiling tile, except for the new construction on the #1 hall. (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 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 5 smoke barrier walls was smoke resistant. The findings were: Observation on 3/10/09 at 3:18 PM revealed the smoke barrier wall between #1 and #2 hall and	K 025	K025 The facility will ensure that smoke barrier walls are alls are smoke resistant. This will be accomplished by: The two unsealed cable penetrations between halls 1 & 2 & Administration hall will be sealed. Monitoring: Director of maintenance will monitor quarterly. 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	05/01/09 4/26/09

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K 025	Continued From page 4 administration hall had two unsealed cable penetrations. The gaps around the cables were 1/2 inch wide. Interview with the maintenance director at the time of observation revealed smoke barrier walls were not routinely inspected above the ceiling tile.	K 025	suggestions.	
K 046 SS=F	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 record review and staff interview the facility failed to ensure one of two emergency battery light tests were conducted in the past year. The findings were: 1. Review of the emergency battery light testing records revealed the annual 90 minute test had not been conducted in the past year. The last test was conducted on 8/17/07. 2. Interview with the maintenance director on 3/10/09 at 4:45 PM revealed he was not aware of this test requirement.	K 046	K046 The facility will ensure one that both emergency battery light tests are conducted yearly. This will be accomplished by: 1. Emergency lighting system will be tested yearly. Monitoring: Director of maintenance will monitor quarterly. 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.	05/01/09 4/26/09
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	K 047	K047 The facility will ensure that exit signs are properly illuminated. This will be accomplished by:	

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K 047	Continued From page 5 facility failed to ensure exit signs were properly illuminated in 3 of 6 smoke compartments. The findings were: Observation on 3/10/09 between 2 PM and 4 PM revealed the exit signs near resident room #307, the laundry and #1 and #2 nurses station did not have both light bulb illuminated. Each location only had one light bulbs illuminated. Interview with the maintenance director at the time of observation revealed the signs were not routinely inspected.	K 047	All exit sign lights that were not working will be replaced. Monitoring: Director of maintenance will monitor quarterly. 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.	~~05/01/09~~ 4/26/09
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure fire drills were conducted on 1 of 3 shifts over the past year and failed to vary the times of drills on 1 of 3 shifts. The findings were: 1. Review of the fire drill records revealed the third shift was from 10 PM to 6 AM. A drill had not been conducted on the third shift in the past year. The last fire drill was conducted on 12/14/07.	K 050	K050 The facility will ensure that fire drills are conducted during all three shifts. This will be accomplished by: 1. A fire drill will be conducted quarterly on the 10pm to 6 am shift. 2. A fire drill will be conducted quarterly on the 10pm to 6 am shift. 3. Fire drills for all three shifts will be conducted at a variety of times. Monitoring: Director of maintenance will monitor quarterly. Any issues noted will be addressed immediately.	~~05/01/09~~ ~~05/01/09~~ ~~05/01/09~~ 4/26/09

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K 050	Continued From page 6 2. Interview with the maintenance director on 3/10/09 at 4:45 PM confirmed a fire drill had not occurred on the third shift in the past year. He further reported that he had not conducted the drill because he did not want to wake the residents. 3. Review of the fire drill records revealed the second shift was from 2 PM to 10 PM. All drills conducted on the second during 2008 occurred between 2:30 PM and 3:30 PM.	K 050	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.	
K 052 SS=F	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 7 of 9 fire alarm system components were tested in the past year. The findings were: 1. Review of the fire alarm system testing records revealed the annunciator panel, annunciator batteries, alarm notification appliances, manual fire alarm boxes, heat detectors, smoke dampers and smoke detectors had not been tested in the	K 052	K052 The facility will ensure that all fire alarm systems are tested yearly. This will be accomplished by: 1. The annunciator panel, annunciator batteries, alarm notification appliances, manual fire alarm boxes, heat detectors, smoke dampers, and smoke detectors will be tested. 2. The facility will have a preventive maintenance system in place as well as a service provider contract in place to test the system. Monitoring: Director of maintenance will monitor quarterly. Any issues noted will be addressed immediately. Quality Assurance:	~~05/01/09~~ ~~05/01/09~~ 4/26/09

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K 052	Continued From page 7 past year. The system was last tested on 7/13/07. 2. Interview with the maintenance director on 3/10/09 at 4:45 PM confirmed the system had not been tested in the past year. He further reported that he was unaware the system was required to be tested annually. He also reported that he did not have a preventative maintenance procedures to prompt him to test the system. He also reported that he was not qualified to test the system and the facility did not have a contract with a service provider to test the system.	K 052	Director of Maintenance will report 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 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 the facility failed to ensure 6 of 6 smoke compartments were fully sprinkled. The findings were: Observation on 3/10/09 between 3 PM and 5 PM revealed the building was primarily constructed of a Type II (111) construction, but several areas	K 056	K056 F	F

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K 056	Continued From page 8 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. (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 one of the past four quarters. The findings were: 1. Review of the domestic fire sprinkler system testing records revealed the waterflow and supervisory signal devices had not been tested during the fourth quarter of 2008. The system was last tested on 7/18/08. 2. Interview with the maintenance director on 3/10/09 at 4:45 PM confirmed the aforementioned	K 062	K062 The facility will ensure the domestic fire sprinkler system is tested quarterly. This will be accomplished by: 1. The water flow and supervisory signal devices will be tested quarterly on the domestic fire sprinkler system. Monitoring: Director of maintenance will monitor quarterly. 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.	~~05/01/09~~ 4/26/09

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K 062	Continued From page 9 tests had not occurred. He also confirmed the facility had a preventative maintenance schedule for testing.	K 062		
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 facility failed to ensure the emergency generator was serviced in the past twelve months. The findings were: 1. Review of the emergency generator testing records revealed the facility did not have record of the last time the generator was serviced. 2. Interview with the maintenance director on 3/10/09 at 4:45 PM revealed he did not have documentation for the last time the generator was serviced. He further reported that he did not have a preventative maintenance procedures to prompt him to service the generator.	K 144	K144 The facility will ensure the emergency generator is serviced yearly. This will be accomplished by: 1. A form will be designed to ensure that the proper maintenance is done on the generator (oil, filter, grease, hr. meter reading). ~~05/01/09~~ 2. A preventive maintenance procedure will be developed to ensure that the generator be serviced. ~~05/01/09~~ 4/24/09 Monitoring: Director of maintenance will monitor quarterly. 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.	
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	K 147	K147 The facility will ensure that electrical systems are properly maintained.	

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K 147	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the electrical system was properly maintained in two of six smoke compartments. The findings were: 1. Observation on 3/10/09 between 1:30 PM and 3 PM revealed the television sets in resident room #103, #105 and #401 were plugged into surge protectors, which were plugged into 6-way adapters. 2. Interview with the maintenance director on 3/10/09 at 1:36 PM revealed he was unaware surge protectors could only be plugged into grounded electrical receptacles.	K 147	This will be accomplished by: 1. The 6-way adapter will be removed from room 401, 105, 105. ~~05/01/09~~ 2. The maintenance director will do quarterly room checks to ensure that electrical receptacles are grounded. ~~05/01/09~~ 4/26/09 Monitoring: Director of maintenance will monitor quarterly. 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.	