

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

WORLD HEALTHCARE

WY Dept of Health

JUN 15 2012

Healthcare Licensing

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLD HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 HOWELL AVENUE WORLD, 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 sprinkled 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 with a census of 84 residents. The facility meets the Life Safety Code standard based on the acceptance of a plan of correction and a Fire Safety and Evaluation System (FSES). Tag K-012, K-017, and K-056 can be obviated by the FSES. If the facility agrees to the conditions of the FSES they can write an "F" in the providers Plan of Correction column and a "F" in the Complete 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 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2	K 011	K 011 The facility will ensure the fire barrier wall is smoke resistant. This will be accomplished by: The self-closing double fire door on the 100 hall has been repaired. Tension was adjusted and ripples on door edges were smoothed.	7/8/12	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: U6BF21

Facility ID: WY0008

If continuation sheet Page 1 of 11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: #35048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 011	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the fire barrier wall was smoke resistant. The findings were: Observation of the 100 hall fire barrier wall on 5/30/12 at 9:46 AM showed the self-closing device one of the two double doors did not latch the door into the door frame, with three attempts. Further observation showed the meeting edges of the doors would bind with each other preventing the door from latching into the door frame. At the time of the observation the maintenance director could not explain why the doors had not been noticed and repaired during the monthly inspection.	K 011	Monitoring: Director of maintenance will monitor weekly. 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 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 facility failed to ensure the minimum construction requirements were met for a wood frame partially-sprinkled building in 6 of 6 smoke compartments. The findings were: Observation on 5/30/12 between 8 AM and 11 AM showed the facility was primarily constructed of	K 012	K012 a. F b. F c. F d. F	F F F F	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012					
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETION DATE						
K 012	Continued From page 2 Type II (111) steel frame construction. The following areas were constructed of combustible materials Type V (000) wood frame construction 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. On 5/30/12 at 8 AM the administrator 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.) Reference, NFPA 101, 2000 Edition; 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Table 19.1.6.2 Construction Type Limitations <table border="1"> <thead> <tr> <th>Construction Type</th> <th>Stories</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>2</td> </tr> <tr> <td>3</td> <td>4 or More</td> </tr> </tbody> </table>	Construction Type	Stories	1	2	3	4 or More	K 012		
Construction Type	Stories									
1	2									
3	4 or More									

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 3 I(443) X X X X I(332) X X X X II(222) X X X X II(111) X X* X* NP II(000) X* X* NP NP III(211) X* X* NP NP III(200) X* NP NP NP IV(2HH) X* X* NP NP V(111) X* X* NP NP V(000) X* NP NP NP X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. K 017: NFPA 101 LIFE SAFETY CODE STANDARD SS=F Corridors are separated from use areas by walls	K 012			
K 017 SS=F		K 017	K 017 F		F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 4 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, 19.3.6.6 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 in 5 of 8 non-sprinklered smoke compartments. The findings were: Observation on 5/30/12 between 8 AM and 11 AM showed the corridor walls on halls #1, #2, #3, and #4 stopped above the ceiling tile, except for the new construction on the #1 hall. On 5/30/12 at 8 AM the administrator confirmed the aforementioned corridor walls did not extended from floor to roof 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	K 017			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 5 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 029 SS=E	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 separated from use areas in 1 of 6 smoke compartments. The findings were: Observation on 5/30/12 at 9:18 AM showed the corridor door to the bio-hazard room in the service corridor was equipped with a self-closing device. Further observation showed the closure was unable to fully latch the door into the door frame, with three attempts. At the time of the observation the maintenance director could not explain why the door was not noticed and repaired during the monthly inspections.	K 029	K 029 The facility will ensure hazardous areas were separated from use areas in all 6 smoke compartments. This will be accomplished by: The Corridor door to the bio-hazard room in the service corridor has been repaired. Self Closure was adjusted and outer door seals replaced. Monitoring: Director of maintenance will monitor weekly. 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.	7/8/12	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 056	K 056 F		F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 6 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 and staff interview, the facility failed to ensure 6 of 6 smoke compartments were fully sprinkled. The findings were: Observation on 5/30/11 between 8 AM and 11 AM showed the building was primarily constructed of Type II (111) steel frame construction, but several areas were observed to have wood construction making the building a Type V (000) structure. The following areas were constructed of combustible materials: 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 vertical shafts in halls #1, #2, #3 and #4.			K 056			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Observation also revealed the building did not have a complete supervised automatic sprinkler system as required by the Code for type V wood frame buildings. However, the facility did have a domestic wet sprinkler system in the file store room, the laundry, and the oxygen transferring room. On 5/30/12 at 8 AM the administrator confirmed the building was only equipped with a domestic sprinkler system. (The Fire Safety Evaluation System (FSSES) 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 FSSES.) Reference, NFPA 101, 2000 Edition; 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 056			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by:	K 064	K 064 The facility will ensure portable fire extinguishers are maintained in all smoke compartments. This will be accomplished by: At 12:45pm on 05/30/12 K-type extinguisher was taken to Frandson Safety for hydrostatic testing. Extinguisher was overhauled and tested. Completed at 4:45pm on 05/30/12.	7/8/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 064	Continued From page 8 Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were maintained in 1 of 6 smoke compartments. The findings were: Observation of the kitchen "K" type portable fire extinguisher on 5/30/12 at 9:01 AM showed the extinguisher was manufactured in 2007. Further review showed the 2012 annual inspection was completed in January 2012, but a five year hydrostatic test had not been performed. At the time of the observation the maintenance director reported he was unaware of the aforementioned requirement. Reference, NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition; 4-4.1 Frequency, Fire Extinguishers shall be subjected to maintenance at intervals of not more than 1 year, and the time of hydrostatic test, of when the specifically indicated by an inspection. Table 5-2 Hydrostatic Test Intervals for Extinguishers Wet Agent-----5 years	K 064	Monitoring: Director of Maintenance will monitor dates of fire extinguishers monthly for compliance on next test due. 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 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075	K075 The facility will ensure soiled linen receptacles have adequate separation in all smoke compartments. This will be accomplished by: Until smaller barrels are received – barrels are to be stored in the appropriate location when not in use, ie. Soiled Utility Room.	7/8/12	

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

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 075	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure soiled linen receptacles had adequate separation in 2 of 6 smoke compartments. The findings were: Observation on 5/30/12 between 8:30 AM and 10:30 AM showed soiled linen receptacles were stored side by side, with less than 8 foot separation in the following locations: a. Five barrels with a 32 gallon capacity were stored in hall 3&4 bathing room. b. Two barrels with a 32 gallon capacity were stored in hall 1&2 bathing room. On 5/30/12 at 8:50 AM the maintenance director reported he was unaware soiled linen receptacles must be separated by 64 square feet or 8 feet apart.	K 075	Monitoring: Director of Maintenance will monitor weekly for compliance. 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 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance	K 143	K143 The facility will ensure the liquid oxygen transferring room has 1-hour fire rated separation. This will be accomplished by: Existing panel was removed along with the frame. It was replaced with 5/8" thick panel with appropriate fire rating. Gaps that appeared after installation were sealed with fire resistive caulking.	7/8/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2012
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 143	Continued From page 10 with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the liquid oxygen transferring room had 1-hour fire rated separation. The findings were: Observation of the liquid oxygen transferring room on 5/30/12 at 9:22 AM showed the attic access door was an unrated 1 foot by 2 foot ceiling tile. At the time of the observation the maintenance director reported he was unaware the room walls and ceiling were required to be 1-hour fire rated.	K 143	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.	