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 _____	**08/01/2019**

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 A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 08/01/19. 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 2012 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 62.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress could result in injury or death in the event of an emergency. The deficiency affected two (2) of six (6) smoke compartments.	K 211	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	9/6/19

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

Electronically Signed | 08/23/2019

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.

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 _____	**08/01/2019**

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 211	Continued From page 1 The findings were: Observation on 08/01/19 at 1:10 PM revealed an exterior sidewalk, which is part of the exit discharge from the dining room and the north east resident wing, was not being maintained and was covered in dirt and overgrown with weeds. As well, the curb from the sidewalk to the parking lot had been eroded away making the transition difficult to walk. Walking surfaces in the means of egress shall be nominally level, not have abrupt changes in elevation and shall be slip resistant. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement and aware of the deficiency. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.1, 7.1.6	K 211	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. K211 The facility will ensure aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency. This will be accomplished by: On August 21, 2019 a contractor was onsite to bid replacement of sidewalk & curbing of the exit discharge from the dining room and the north east resident wing. Bid was received on August 22, 2019 in the amount of $3140.00 and was accepted. Contractor has scheduled work to completed "middle" of September. Monitoring: The Maintenance Supervisor/Designee will conduct weekly inspections to ensure that all means of egress are free of all obstructions and are fully accessible. Quality Assurance: The Maintenance Supervisor/Designee will report results of monitoring monthly to	

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 _____	**08/01/2019**

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 211	Continued From page 2	K 211	the Quality Assurance Performance Improvement to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	
K 231 SS=F	Means of Egress Capacity CFR(s): NFPA 101 Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress could result in injury or death in the event of an emergency. The deficiency affected six (6) of six (6) smoke compartments. The findings were: Observation on 08/01/19 at 1:02 PM and throughout the survey revealed that the facility was keeping stools in the corridors for use by the staff at the nurse's kiosks. The stools projected approximately 18 to 24 inches into the 8 foot corridor and were not fixed to the floor or wall. Fixed furniture is allowed in the corridor as long as it meets all the conditions of the referenced code section. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement and aware of the deficiency.	K 231	K231 The facility will ensure means of egress capacity in accordance with 7.3. This will be accomplished by: The Maintenance Supervisor will remove stools located in the facility corridors on or before alleged date of compliance. Monitoring: The Maintenance Supervisor/Designee will conduct weekly inspections of the corridors and remove or secure furniture located in the corridors as needed. Quality Assurance: The Maintenance Supervisor/Designee will report results of monitoring monthly to the Quality Assurance Performance Improvement to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	9/6/19

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 _____	**08/01/2019**

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 231	Continued From page 3 Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.2.3.4	K 231		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		9/6/19

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 _____	**08/01/2019**

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 321	Continued From page 4 Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect hazardous areas could result in injury or death in the event of a fire. The deficiencies affected three (3) of six (6) smoke compartments. The findings were: Observation on 08/01/19 at 12:52 PM revealed the activities office had large amounts of combustible storage in it, and there was a door closer installed on the office door, but it had been deactivated. Hazardous areas that are protected with an automatic extinguishing system shall have doors that are self-closing or automatic-closing. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.3 Observation on 08/01/19 at 1:30 PM revealed the central supply room had a large opening in the ceiling above the suspended air handling unit. Hazardous areas shall be protected by smoke partitions. Where the walls of the area do not extend to the underside of the roof deck above, the ceiling system shall form a continuous membrane. Interview with the facilities manager at the time of	K 321	K321 The facility will protect hazardous areas in accordance with the 2012 NFPA 101, Life Safety Code in 6 of 6 smoke compartments. This will be accomplished by: The Maintenance Supervisor will install an automatic door closer in the bathing area located near Room 111. The Activity Office will have its storage removed from the office to reduce the amount of combustible material located in that particular office. The Maintenance Supervisor will have the large opening above the air handler located in Central Supply closed and sealed on or before the alleged date of compliance. Monitoring: The Maintenance Supervisor/Designee will conduct monthly inspections of hazardous areas and correct noncompliance immediately. Quality Assurance: The Maintenance Supervisor/Designee will report results of monitoring monthly to the Quality Assurance Performance Improvement to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	

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 _____	**08/01/2019**

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 321	Continued From page 5 the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.2, 8.4.2 (2) Observation on 08/01/19 at 2:03 PM revealed the bathing room near resident room 111 was being used as a storage room. The door appeared to have had an automatic door closer that was removed. Hazardous areas that are protected with an automatic extinguishing system shall have doors that are self-closing or automatic-closing. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.1.3	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		9/6/19

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 _____	**08/01/2019**

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 324	Continued From page 6 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain cooking facilities could result in injury or death. The deficiency affected one (1) of six (6) smoke compartments. The findings were: Document review on 08/01/19 at 2:20 PM revealed the facility had the kitchen range hood exhaust system inspected and cleaned once in the last 12 months. Kitchen range hood exhaust systems shall be inspected once every six months and cleaned as necessary. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were unaware of the requirement.	K 324	K324 The facility will maintain cooking facilities in accordance with the 2012 NFPA 101, Life Safety Code. This will be accomplished by: The Kitchen Exhaust Range Hood inspection will be inspected every 6 months. The inspection report will be received via email within a week of the inspection and filed. Monitoring: The Maintenance Supervisor/Designee will assure that the documentation needed for verification of inspection will be available upon request. Quality Assurance: The Maintenance Supervisor/Designee	

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 _____	**08/01/2019**

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 324	Continued From page 7 Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.2.5.1, 9.2.3; 2011 NFPA 96 11.4	K 324	will report results of monitoring monthly to the Quality Assurance Performance Improvement to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain smoke barriers could result in injury or death in the event of a fire. The deficiency affected two(2) of six (6) smoke compartments. The findings were: Observation on 08/01/19 at 2:10 PM revealed the smoke compartment barrier adjacent to the dementia unit had unprotected plumbing and electrical wire penetrations. All penetrations of a	K 372	K372 The facility will ensure that smoke barriers are constructed to a ¿ hour fire resistance rating per 8.5. This will be accomplished by: On or before the allegation date of compliance the Maintenance Supervisor will fill the unprotected plumbing and electrical wire penetrations adjacent to the dementia unit with fire rating caulking. Monitoring: The Maintenance Supervisor/Designee	9/6/19

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 _____	**08/01/2019**

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 372	Continued From page 8 smoke barrier shall be protected by a system or material capable of restricting the transfer of smoke. Interview with the facility manager at the time of the observation acknowledged the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. Reference: 2012 NFPA 101 19.3.7.3, 8.5.6.2	K 372	will conduct weekly inspections of the 5 smoke barriers to ensure there are no unprotected penetrations. Quality Assurance: The Maintenance Supervisor/Designee will report results of monitoring monthly to the Quality Assurance Performance Improvement to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	08/01/2019

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 08/01/19.	E 000		
E 024 SS=F	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		9/6/19

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

Electronically Signed | 08/23/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	08/01/2019

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
E 024	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide policies or procedures for use of volunteers in an emergency. The findings were: Document review of the Emergency Preparedness Plan on 08/01/19 at 3:00 PM revealed the facility did not have policies or procedures addressing the use of volunteers in an emergency or other emergency staffing strategies. Interview with facilities manager revealed that they believed a policy was in place but was unable to find it in the emergency preparedness plan.	E 024	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. E024 Corrective Action: The community now has a policy in place addressing use of volunteers in an emergency. Identification: Residents residing in the facility have the potential to be affected by this deficient practice. Systematic changes: Facility will ensure policy is in place addressing use of volunteers in an emergency. Monitoring: Procedures put in place will be reviewed in QAPI annually for the purpose of process improvement and to assure the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	08/01/2019

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
E 024	Continued From page 2	E 024	plan has been implemented, sustained and evaluated for its effectiveness. Issues identified through this review will be discussed and re-evaluated in QAPI.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		9/6/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	08/01/2019

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
E 039	Continued From page 3 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct all required exercises for the last 12 months. The findings were: Document review of the Emergency Preparedness Plan on 08/01/19 at 3:00 PM revealed the facility had experienced an actual emergency that required activation of the emergency plan, but had not conducted an additional full-scale exercise or tabletop exercise in the last 12 months.	E 039	E039 Corrective Action: By the date of compliance the facility will conduct a table top exercise. Identification: Residents residing in the facility have the potential to be affected by this deficient practice Systematic changes: Facility will complete the required staff training of the emergency procedures along with the completion of the required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING _____ B. WING _____	08/01/2019

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
E 039	Continued From page 4 Interview with facility manager revealed that they were aware of the requirement, but had not participated in an additional exercise.	E 039	community-based exercises annually. Monitoring: Procedures put in place will be reviewed in QAPI for the purpose of process improvement and to assure the plan has been implemented, sustained and evaluated for its effectiveness. Issues identified through this review will be discussed and re-evaluated in QAPI	