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 _____	**03/06/2025**

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 03/06/2025. The findings that follow demonstrate noncompliance with 42 CFR 483.73.	E 000		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced	E 009		4/4/25

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

Electronically Signed | 03/28/2025

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E 009	Continued From page 1 by: Based on document review and staff interview, the facility failed to provide a process for cooperation and collaboration with emergency preparedness officials as required in accordance with §483.73(a)(4). Failure to provide a process for cooperation and collaboration with emergency preparedness officials may result in an inadequate integrated community response in the event of an emergency. The deficiency has the potential to affect all residents, staff, and visitors. The findings were: Document review on 03/06/2025 starting at 12:30 PM revealed that documentation was not available to demonstrate that the facility was involved and cooperating with the regional emergency preparedness coalition. Interview with facility staff revealed the facility was not in communication with, or attending meetings for, the regional public health coalition. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the director of nursing and MDS coordinator at the time of exit confirmed the deficiency.	E 009	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. E009 The facility will develop and maintain and emergency preparedness plan that will be reviewed, and updated annually. The plan will include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials efforts to maintain an integrated response during a disaster or emergency situation. This will be accomplished by: On March 10, 2025 the Maintenance Director reached out to the Director of Washakie County Emergency Management to find out how to be involved in local emergency management. The Director responded with all the details. Next meeting is April 3, 2025 at 2:00pm at the Washakie County	

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E 009	Continued From page 2	E 009	Fairgrounds and Maintenance Director will attend. Monitoring: The Maintenance Director/Designee will attend the Local Emergency Management Planning Committee Meetings every other month on the third Thursday. Minutes from Emergency Management Meetings will be added to the ERP. Will involve Local Emergency Management in facility emergency planning PRN. Quality Assurance: The Maintenance Director/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.	
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 03/06/2025. Requirements for Long Term Care Facilities Section 42 CFR 483.90, except as otherwise provided in this 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, one story building of Type II (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	K 000		

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K 000	Continued From page 3 a capacity of 87 certified Medicare and Medicaid beds with a census of 76 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.	K 222		4/4/25

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K 222	Continued From page 4 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly lock egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly lock egress doors could result in the delay or inability to egress in the event of an emergency, resulting in injury or death. The deficiency affected the north west resident wing, and could potentially affect all residents, staff, and visitors in that area. The findings were:	K 222	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	

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K 222	Continued From page 5 Observation on 03/06/25 at 11:39 AM revealed a pair of cross-corridor doors that were improperly locked. Observation of the cross corridor doors in the north west resident corridor, which act as security doors for the secure resident unit, were equipped with delayed-egress hardware. Testing of the doors revealed that the delayed-egress system would not activate and in order to egress through the doors staff had to use the adjacent keypad. It was also observed that the doors did not have the proper signage for delayed-egress doors. Doors equipped with delayed-egress hardware shall unlock within fifteen (15) seconds after a force is applied for not more than three (3) seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. The door shall also have a sign that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the director of nursing and MDS coordinator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101 19.2.2.2.4, 7.2.1.6.1	K 222	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. The facility will properly lock egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Doors in a required means of egress will not be equipped with a latch or a lock that requires the use of a tool or key from the egress side. This will be accomplished by: On March 26, 2025 the Maintenance Director contacted RF Technologies, the facility wander guard system, to come and install a fully functioning delayed egress system on the Special Care Unit Doors. On March 27, 2025 the Executive Director signed the “On-site contract,” so scheduling for installation can proceed. Monitoring: The Maintenance Director/Designee will monitor weekly for one month then monthly for three months. Monitoring will be logged into the Life Safety Book. Quality Assurance: The Maintenance Director/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.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		4/4/25

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K 321	Continued From page 6 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: Based on observation and staff interview, the facility failed to protect hazardous area in accordance with the 2012 NFPA 101, Life Safety Code. Failure to properly protect hazardous areas could result in the spread of smoke and fire in the event of a fire, resulting in injury or death. The deficiency affected the kitchen area, and could	K 321	The facility will ensure hazardous areas are protected by a fire barrier having 1-hour fire resistance rating or an automatic fire extinguisher system. Doors shall be self-closing or automatic closing and permitted to have nonrated or field applied protective plates that do not	

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K 321	Continued From page 7 potentially affect all kitchen staff and visitors. The findings were: Observation on 03/06/25 at 11:03 AM revealed a hazardous storage room that was not properly protected. Observation revealed that a former office in the kitchen area was being utilized to store a large amount of combustible materials. It was observed that the door to the room was not automatic-or self-closing. Rooms larger than 50 s.f. being used for storage of combustible supplies and equipment shall be considered hazardous areas, and shall have doors that are automatic-closing or self-closing. Interview with the maintenance director at the time of observation acknowledge the deficiency, and indicated that they were aware of the requirement. Interview with the director of nursing and MDS coordinator at the time of exit confirmed the deficiency. Ref: 2012 NFPA 101, 19.3.2.1.3	K 321	exceed 48 inches form the bottom of the door. This will be accomplished by: On March 11, 2025 the Maintenance Director/Designee installed an automatic door closer on the door between the kitchen and the storage area. Monitoring: The Maintenance Director/Designee will monitor monthly for three months to ensure compliance. Monitoring will be logged into the Life Safety Book. Quality Assurance: The Maintenance Director/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.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		4/4/25

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K 918	Continued From page 8 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to test and maintain the essential electrical system (EES) in accordance with the 2012 NFPA 99, Health Care Facilities Code. Failure to properly test and maintain the EES could result in a failure of the system, resulting in injury or death in the event of an emergency. The deficiency affected the EES, and could potentially affect all residents, staff, and visitors. The findings were:	K 918	The facility will test and maintain the essential electrical system in accordance with the 2012 NFPA 99 Health Facilities Code. The facility will properly test and maintain the essential electrical system in accordance. This will be accomplished by: On or before the alleged compliance date, the facility will contact the emergency breaker box manufacturer for recommendation on testing the breaker.	

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K 918	Continued From page 9 Document review on 03/06/2025 starting at 1:15 PM revealed that the facility failed to perform the inspection and testing of main and feeder circuit breakers. No documentation was available at the time of the survey to demonstrate that the facility had conducted the annual inspection of the main and feeder circuit breakers associated with the EES. No maintenance program was available for periodically exercising the components in accordance with manufacturer's recommendation. Interview with the maintenance director at the time of the observation acknowledge the deficiency, and indicated that they were unaware of the requirement. Interview with the director of nursing and MDS coordinator at the time of the exit confirmed the deficiency. Ref: 2010 NFPA 99 6.4.4.1.2.1	K 918	The facility will then contact the electrical contractor to complete according to the recommendation. Monitoring: The Maintenance Director/Designee will monitor as needed but no less than annually. Monitoring will be logged into the Life Safety Book. Quality Assurance: The Maintenance Director/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.	