| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 53A049 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 03/05/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOSHEN CARE CENTER | 2009 LARAMIE STREET<br>TORRINGTON, WY 82240 |

4/9/07

| (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 |
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| K 011 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, the facility failed to seal penetrations in 1 of 1 fire rated assembly. The finding was:<br>Observation on 3/05/07 at 3:49 PM revealed the vertical 2-hour fire barrier wall separating the nursing home from the hospital had three cable penetrations sealed with an expanding foam which was not fire rated. The can of expanding foam was found in the ceiling cavity at the fire barrier and the foam was not fire rated. | K 011 | The three cable penetrations found in the fire barrier wall between the hospital and the nursing home were properly sealed with fire barrier caulk and fire barrier intumescent sealant on 03/07/07. Both of these products are UL classified and FM approved. These will be monitored monthly by the maintenance staff and changes reported to Safety Committee to insure that the seal is maintained.<br><br>POC ACCEPTED W/LOWEST POSTED, CHIEF NURSING OFFICER, ON 4/9/07 | 3/07/07 |
| K 027 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 | K 027 | The smoke barrier door on the 300 hall and the smoke barrier door near the administrative offices were adjusted by plant operations departmental staff and now close according to NFPA code. Monitor monthly and report to Safety Committee monthly.<br><br>CERTIFIED MAIL™<br>7005 1820 0003 6628 0549 | 3/05/07 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | CEO | MARCH 29, 2007 |

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.

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Licensing and Surveys

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| K 027 | Continued From page 1<br>This STANDARD is not met as evidenced by:<br>Based on observations, the facility failed to maintain 2 of 10 smoke barrier doors. The findings were:<br>Observation on 3/05/07 between 2:30 PM and 4 PM revealed the following smoke barrier doors were not smoke resistant because they would not latch into the frames:<br>a. One of two doors on the 300 hall.<br>b. One of two doors near the administrative offices. | K 027 | | |
| K 038<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, the facility failed to maintain 3 of 6 smoke compartments egress corridors unobstructed and accessible at all times. The findings were:<br>Observation on 3/05/07 between 2:30 PM and 3 PM revealed the following corridors were obstructed:<br>a. The 300 hall corridor was obstructed by two straight back chairs near the nurses station.<br>b. The 400 hall corridor was obstructed by three straight back chairs near the nurses station.<br>c. The corridor alcove near restorative care was obstructed by four wheelchairs projecting two feet into the corridor. | K 038 | a & b. Corridor egress will remain unobstructed. Monitor these monthly with safety walk-throughs and will report to PI Steering Committee quarterly and Safety Committee monthly.<br>c. Corridor alcove by restorative care will remain unobstructed. Will store extra wheelchairs in appropriate storage area. | 04/16/07 |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under | K 050 | Policy and Procedure will be revised and facility will provide mandatory fire drill training for all staff that will cover all | 4/16/07 |

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| K 050 | Continued From page 2<br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and staff interview, the facility staff were not familiar with the emergency actions required for fire drills and fire drills were not held on 1 of 3 shifts on a quarterly basis. The findings were:<br>1. Observation on 3/05/07 at 4:01 PM revealed the first responder entered the fire room three times and did not recognized the fire flag. Maintenance personal showed the first responder the fire flag on the residents bed.<br>2. Interview with the Plant Operations Manager on 3/05/07 at 4:29 PM revealed the facility had not called 911 as required by the Code Red Procedure policy. When the fire department was called to take the facility off the drill mode the dispatch officer informed the Plant Operations Manager that no one from the facility had called 911.<br>3. Review of the fire drills records revealed the third shift had not conducted a fire drill during the third quarter of 2006.<br>4. Interview with the Plant Operations Manager on 3/05/07 at 12:30 PM revealed there were no other records to review. | K 050 | aspects of fire drills. Will be using a strobe instead of a flag for darker areas during drills. Reminder will be made available through Outlook. Report to Safety Committee monthly on training progress. | |
| K 052 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD | K 052 | 1 & 2. Contacted licensed fire alarm system company and informed them that | 3/06/07 |

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| K 052 | Continued From page 3<br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to properly test 2 of 8 fire alarm components. The findings were:<br>1. Review of the fire alarm system testing records revealed the smoke detectors had not been tested with smoke entering the sensing chamber.<br>2. Interview with the Plant Operations Manager on 3/05/07 at 12:25 PM revealed the smoke detectors had been tested with a magnet triggering an alarm response.<br>NFPA 72 Table 7-2.2 Section 13 (g) 1. states "The detectors shall be tested in place to ensure smoke entry into the sensing chamber and an alarm response..."<br><br>3. Review of the fire alarm system testing records on revealed the monthly fire alarm receiver test had not been performed for the month of August 2006.<br>NFPA 72 Table 7-3.2 Section 23 states "All Supervising station Fire Alarm Systems, Receivers shall be tested on a monthly basis." | K 052 | the smoke detectors need to be tested with canned smoke and not magnets.<br>3. Drills done in the middle of the night will be tabletop drills, but the pull station used for that drill will be alarmed the next day to ensure that all pull stations alarm to Police Station. Monitored and reported to Safety Committee monthly. | |

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| K 052 | Continued From page 4<br>4. Interview with the Plant Operations Manager on 3/05/07 at 12:30 PM revealed there were no other records to review. | K 052 | | |
| K 056<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, the facility failed to install 3 of 435 fire sprinkler heads no further than the maximum allowed distance from the ceiling. The finding was:<br>Observation on 3/05/07 at 3:31 PM revealed the main storage room had 3 of 7 fire sprinkler heads installed more than the maximum allowed 12 inches below the unobstructed ceiling cavity. NFPA 13 Section 5-6.4.1.1 Under unobstructed ceilings, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 in. and a maximum of 12 in. | K 056 | Three sprinkler heads have been extended to the maximum 12 inches below the unobstructed ceiling cavity as required by NFPA 13. | 03/07/07 |
| K 062<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating | K 062 | 1. Missing ceiling tile was replaced and will educate maintenance staff on replacing tiles upon completion of tasks.<br>2. a. Removed shelf from janitor closet in | 3/06/07<br><br>3/06/07 |

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| K 062 | Continued From page 5<br>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>Based on record review, observations on 1 of 1 day and staff interview, the facility failed to test 3 of 7 fire sprinkler components and maintain the installed sprinkler system. The findings were:<br>1. Observation on 3/05/07 at 2:20 PM revealed the ceiling above the 200 hall exit was not a smooth continuous membranes. A ceiling tile was missing near the exit sign.<br>NFPA 13 Section 1-4.6 states "...other members do not impede heat flow or water distribution in a manner that materially affects the ability of sprinklers to control or suppress a fire..."<br><br>2. Observation on 3/05/07 between 2 PM and 3 PM revealed the following areas had items stored closer than the allowed 18 inches below the sprinkler head deflector:<br>a. 1 of 1 sprinkler head in the servery janitors closet.<br>b. 1 of 1 sprinkler head in the closer in resident room #308.<br>NFPA 13 Section 5-6.5.3 states "...obstructions that interrupt the water discharge in a horizontal plane more than 18 in. below the sprinkler deflector in a manner to limit the distribution from reaching the protected hazard shall comply with this section."<br><br>3. Review of the sprinkler testing records revealed the annual dry sprinkler system valve trip test had not been performed in the past year. The last annual trip test was performed on | K 062 | servery and notified dietary staff that 18 inches below ceiling must be maintained.<br>b. Removed boxes and all other items from the top shelf in resident room #308 and will monitor monthly with safety walk-through.<br>3 & 4. Contracted with new licensed company which will be in the facility on 4/10/07 to test sprinkler system. Will implement test reminder through TMA program. Will report to PI Steering Committee quarterly. 3 year dry sprinkler system full flow trip test will be conducted summer 2007 due to having to do the test during warmer weather. Will have calendar schedule at that time. ~~WAIVER REQUESTED~~ ROUTINE TESTING<br>5. Contracted with a company from Cheyenne to do backflow preventer test that will be completed. Test results will be filed in Life Safety book in maintenance office and a PM generated in TMA program. Report to Safety Committee monthly. | 3/06/07<br><br>4/10/07<br><br>4/20/07 |

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| K 062 | Continued From page 6<br>November 1, 2005.<br>NFPA 25 Section 9-4.4.2.2 states "Each dry pipe valve shall be trip tested annually during warm weather."<br><br>4. Review of the sprinkler testing records revealed the 3 year dry sprinkler system full flow trip test had not been tested in the past 3 years. The last full flow trip test was performed on September 6, 2002.<br>NFPA 25 Section 9-4.4.2.2.1 states "Every 3 years and whenever the system is alerted, the dry pipe valve shall be trip tested with the control valve fully open and the quick-open device, if provided, in service."<br><br>5. Review of the sprinkler testing records revealed the backflow preventer installed in the fire protection system had not been tested.<br>NFPA 25 Section 9-6.2.1 states "All backflow preventers installed in fire protection system piping shall be tested annually..."<br><br>6. Interview with the Plant Operations Manager on 3/05/07 at 12:30 PM revealed there were no other records to review. | K 062 | | |
| K 068<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and record review, the facility failed to maintain 1 of 1 outside air vent for combustion of fuel fired clothing driers. The | K 068 | 1. Sheet metal that was blocking outside air to the fuel fired clothing driers was removed.<br>2. Facility is scheduling with engineer to rectify air flow. | 3/06/07<br><br>3/07/07 |

DEPARTMENT OF HEALTH AND HUM. , SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2007
FORM APPROVED
OMB NO. 0938-0391

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| K 068 | Continued From page 7<br>findings were<br>1. Observation on 3/06/07 at 2:03 PM revealed about half o fthe only air vent supplying outside air to the fuel fired clothing dries was blocked with sheet metal.<br>2. Record review of a contractors assessment of the outside air intake vents states "...At this time the fresh air has been cut off to prevent flame failures. This opening is not large enough for the current Code..." | K 068 | | |
| K 070 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8<br><br>This STANDARD is not met as evidenced by:<br>Based on observations the facility failed to prohibit portable space heaters in 1 of 108 rooms. The finding was:<br>Observation on 3/05/07 at 3:25 PM revealed the Director of Nurses office had a portable space heater plugged into an electrical receptacle. | K 070 | Policy and Procedure written that indicates heaters will be allowed in non-sleeping staff and employee areas and said heaters will be tested by maintenance before use in facility and test annually. Heaters will not exceed 212 degrees F at surface. Will be monitored monthly by maintenance and by safety walk-through. | 4/16/07 |

REMOVED DUE TO INFORMAL DISPUTE RESOLUTION
4/18/07 Jean McLean, RD, Manager
Office of Healthcare Licensing and Surveys

REMOVED DUE TO INFORMAL DISPUTE RESOLUTION
4/18/07 Jean McLean, RD, Manager
Office of Healthcare Licensing and Surveys





L Poten RN, CNO
4/5/07

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| | REMOVED DUE TO INFORMAL DISPUTE RESOLUTION<br>4/18/07 Jean McLean, RD, Manager<br>Office of Healthcare Licensing and Surveys | | | |
| K 144<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in | K 144 | Staff education on completion of test log. Full load tests are done monthly by maintenance and will be reported to PI Steering Committee quarterly. | 4/02/07 |

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| K 144 | Continued From page 9<br>accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review the facility failed to collect 2 of 12 transfer times for the installed emergency generator in the past year. The findings were:<br>1. Review of emergency generator testing records revealed the transfer time from one energy source to another had not been collected for the months of September and December, 2006. NFPA 101 Section 7.9.1.2 states "Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted."<br><br>2. Interview with the Plant Operations Manager on 3/05/07 at 12:30 PM revealed there were no other records to review. | K 144 | | |
| K 147<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations on 1 of 1 day the facility the facility failed to prohibit the use of extension cords and failed to provide covers on all electrical junction boxes. The findings were:<br>1. Observation on 3/05/07 between 2 PM and 3 | K 147 | Policy and Procedures written to prohibit all temporary electrical wiring. Will be monitored monthly by safety walk-through and reported to Safety Committee monthly.<br>1a & b. Extension cords that were found in resident rooms 201 and 210 were removed and replaced with surge protector bars.<br>2. Smoke detector was repaired and parts were ordered. Smoke heads will be monitored monthly by safety walk-through and reported to Safety Committee monthly. | 4/16/07<br><br>3/06/07<br><br>3/07/07 |

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| K 147 | Continued From page 10<br>PM revealed the following locations had temporary electrical wiring replacing permanent wiring due to insufficient electrical receptacles:<br>a. Resident room #201 had a lamp plugged into an extension cord.<br>b. Resident room #210 had the television plugged into an extension cord.<br>NFPA 70 Section 400-8 states " Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following:<br>(1) As a substitute for the fixed wiring of a structure"<br><br>2. Observation on 3/05/07 at 2:29 PM revealed the junction boxes in which resident room #408 smoke detector was attached did not have a cover. The pre-formed screw holes in the smoke detector's base had been broken off so the base could not be attached to the junction box.<br>NFPA 70 Section 370-28 states "Pull and Junction Boxes.<br>(3) (c) cover. All pull boxes, junction boxes and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use..." | K 147 | | |