STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	12/22/2011

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

(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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA-Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MAR-Medication Administration Record MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	Plan: The facility will ensure that every resident will have an initial and periodic comprehensive, accurate, standardized reproducible assessment of functional capacity, using the resident assessment instrument. This will be accomplished by: 1. CAA for resident #19 are completed by the appropriate staff, in the required time frame. They are located in the chart and are in paper form. 2. CAA for resident #23 that were triggered for further assessment are communication, psychosocial well-being, mood and urinary incontinence. The interdisciplinary care team will meet on January 30th to evaluate all triggered areas on the CAA to ensure accuracy of the assessments. Participation will be documented along with a summary of the findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Kordell | TITLE: Administrator | (X6) DATE: 1/20/12

Accepted, no changes needed.
Left voice message for NHA Natalie Kordell on 1/27/12

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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure CAAs were completed on 6 of 14 sample residents (#19, #23, #26, #48, #60, and #63). The findings were: 1. Medical record review for resident #19 revealed a significant change MDS assessment completed on 6/17/11. On section V the areas triggered for further assessment included psychotropic medications, pressure ulcers, and urinary incontinence. Further review showed the CAAs for these areas were blank. 2. Medical record review for resident #23 revealed a significant change MDS assessment dated 7/15/11. On section V the areas triggered for further assessments included communication, psychosocial well-being, mood, and urinary incontinence. Further review showed the CAAs for these areas were blank.	F 272	3. CAA for resident #26 are completed by the appropriate staff, in the required time frame. They are located in the chart and are in paper form. 4. CAA for resident #48 will be opened for a significant change by February 1st. 5. CAA for resident #60 that required further assessment are communication and incontinence. The interdisciplinary care team will meet on February 1st to evaluate the triggered areas on the CAA to ensure accuracy of the assessments. Participation will be documented along with a summary of the findings. 6. CAA for resident #63 that required further assessment are falls. The interdisciplinary care team will meet on February 1st to evaluate the triggered area on the CAA to ensure accuracy of the assessment. Participation will be documented along with a summary of findings. Action: 1. Education to all staff that enter information into the MDS/CAA by January 30th. 2. Documentation of summary information regarding the additional assessment performed on the CAA triggered by the completion of the MDS will be entered into the chart by the licensed staff responsible for the assessment. 3. Documentation in Section V of the comprehensive assessment will be completed by the responsible licensed	

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F 272	Continued From page 2 3. Medical record review for resident #26 revealed an admission MDS assessment dated 6/27/11. Review of section V showed urinary incontinence was triggered for further assessment. Further review showed the CAAs for this area was blank. Interview on 12/20/11 at 9:30 AM with the MDS coordinator revealed residents #19, #23, and #26 all lived in the secure unit. She further confirmed that another nurse was responsible for completing the MDS assessments in June and July 2011, and that the identified CAAs were not completed. 4. Review of the 9/13/11 annual MDS assessment, section V, showed resident #48 triggered for nutrition and required additional assessment. Review of the 9/6/11 CAA summary showed an assessment had not been completed. 5. Review of the 9/26/11 admission MDS assessment, section V, showed resident #60 triggered for communication and required additional assessment. Review of the 9/26/11 CAA summary for this area showed an assessment was not completed. Further, incontinence was triggered for additional assessment, and the review showed the assessment was incomplete. During an interview with the MDS coordinator on 12/22/11 at 9 AM she stated the reason resident #60 was incontinent was due to his/her advanced age. She further acknowledged the CAA summary for resident #48 and #60 for communication needed to be completed. 6. Record review for resident #63 revealed an	F 272	staff for the triggered area to show that adequate data was collected to provide an individualized plan of care. Audit: Every Comprehensive assessment will be audited by clinical admin every week and reported to Performance Improvement monthly.	2-1-12

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F 272	Continued From page 3 8/11/11 admission MDS assessment. Review of section V for this MDS assessment identified falls as one of the areas that triggered and required an additional assessment. Review of the CAA summary showed the assessment information for falls was left blank. An interview with the MDS coordinator on 12/22/11 at 9 AM revealed she had identified falls for the resident as having required an additional assessment, but failed to complete that assessment.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	Plan: The facility will ensure that MDS assessment accurately reflect the resident's status. This will be accomplished by: a. Resident #48 will have a significant change assessment opened by February 1st. To ensure that the assessment accurately reflect the current status. Action: 1. Education to all staff that enter information into the MDS/CAA by January 30th. 2. A copy of the wound care nurses recommendations will go to the MDS coordinator to ensure that data accurately reflects on current MDS/CAA. 3. A copy of doctor orders will go to the MDS coordinator to ensure that data accurately reflects on the current MDS/CAA.	

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F 278	Continued From page 4 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure the MDS assessment accurately reflected the current status for 1 of 16 sample residents (#48). The findings were: Medical record review for resident #48 showed s/he had diagnoses to include Alzheimer's disease and depression. The following concerns were identified: a. Review of the 11/29/11 quarterly MDS assessment showed resident #48 was unsteady when moving from a seated to standing position and transfer between the bed, chair or wheelchair. Observation on 12/20/11 at 8:30 AM showed the resident was transferred with a total lift. Interview with the CNA #1 at that time stated the resident has not been able to stand for 6-7 months. b. Further review for resident #48 concerning mobility devices showed the resident normally used a wheelchair for mobility. During random observations on 12/19/11-12/20/11 showed the resident was in a reclined geri-chair while out of bed. Interview with the wound care nurse on 12/20/11 at 8:30 AM revealed the resident had been using a geri-chair for several months. c. In addition, the assessment showed for skin treatment that resident #48 only had a pressure reducing device for his/her bed. Observation on 12/19/11 at 5:20 PM showed	F 278	Audit: Will be conducted by the MDS Coordinator every thirty days for the previous month assessments and reported to Process Improvement quarterly.	2-1-12

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F 278	Continued From page 5 CNAs #2 and #3 applied protective ointment to the resident's buttock. The CNAs also stated the resident was to be turned every two hours. Review of the 9/26/11 wound assessment document showed pressure relieving measures were in place and protective ointment was to be used. d. Interview with the MDS coordinator on 12/22/11 at 8:20 AM acknowledged the MDS assessment did not include all the treatments the resident received. Further, she stated she relied on the nursing staff to inform her of updates and changes in the resident's care. She acknowledged it was difficult to keep up with all the changes for 90 residents.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Plan: The facility will ensure that every resident has an comprehensive plan of care based off the results of MDS assessment. The plan of care will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. This will be accomplished by: 1. Resident #52 will have an update to her care plan to accurately reflect: medication changes that have occurred, and the use of the sit to stand lift. The interdisciplinary care team will meet February 1st to review changes. Documentation of participation will be made on the individual care plan. 2. Resident #60 will have an update to her care plan to accurately reflect preventive measures that are in place.	

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and observations, the facility failed to ensure the care plans were developed, reviewed and revised for 2 of 16 sample residents (#52, #60). The findings were: 1. Medical record review showed resident #52 had diagnoses to include: depression, dementia, and osteoarthritis. The following concerns were identified: a. Review of the resident's care plan last reviewed on 10/26/11 showed s/he received an antidepressant medication. Review of the May 2011 MAR showed Lexapro (an antidepressant) was discontinued, and no other antidepressant medications were ordered. Further review of the physician orders showed the medication was not reordered. Interview with the MDS coordinator on 12/22/11 at 9 AM confirmed the resident was no longer on the medication. b. Observation on 12/19/11 at 5:30 PM showed the resident was transferred from his/her chair to the bathroom using the sit-to-stand lift. Review of the care plan showed the facility failed to address the sit-to-stand lift used for the resident's transfers. 2. Review of the admission order form dated 9/13/11 showed resident #60 had a pressure ulcer on his/her coccyx. Review of the December 2011 prn (as needed) MAR showed the resident received protective ointment to the perineum and buttocks and pressure redistribution measures twice daily. Observation on 12/20/11 at 8:40 AM	F 279	The interdisciplinary care team will meet February 1st to review changes. Documentation of participation will be made on the individual care plan. Action: 1. A copy of the wound care nurses recommendations will go to the MDS coordinator to ensure that data accurately reflects on the current Care Plan. 2. A copy of doctor orders will go to the MDS coordinator to ensure that data accurately reflects on the current Care Plan. Audit: Will be conducted by the MDS Coordinator every thirty days for the previous month and reported to Process Improvement quarterly.	2-1-12

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F 279	Continued From page 7 showed the resident had a cushion in his/her wheel chair. Review of the resident's care plan last reviewed October 2011 showed no preventive measures in place. Interview with the MDS coordinator on 12/22/11 at 8:20 AM acknowledged the care plan did not include the preventive measures.	F 279		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure measures were in place to prevent the development of a Stage I pressure ulcer for 1 of 7 sample residents (#48) who were identified at moderate to high risk for the development of pressure ulcers. The findings were: Review of the 11/29/11 quarterly MDS assessment showed resident #48 was totally dependent on staff for bed mobility. Review of the wound assessment document dated 9/26/11 showed the resident had two Stage II pressure ulcers on his/her right buttock. The wound assessment document dated 10/3/11 showed the	F 314	Plan: The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores form developing. This will be accomplished by: 1. Resident #48 is currently being seen by wound care nurse. The following preventative measures have been put into place: Repositioned every two hours while in bed, offload every thirty minutes while in chair. Protective ointment to peri area BID and when incontinent. Action: 1. Education: Wound prevention and high risk residents; to be provided to nursing staff on January 30th. 2. Documentation of turning of residents will be on a turn sheet, and signed off by nursing every shift.	

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F 314	Continued From page 8 pressure ulcers had healed. The following concerns were identified: a. Review of the Braden Scale dated 11/23/11 showed the resident was at high risk for developing pressure ulcers. b. Observation on 12/19/11 from 2:30 PM-5:20 PM (2 hours 50 minutes) showed the resident remained in his/her bed and had not been repositioned. At 5:20 PM CNAs #2 and #3 changed the resident's wet incontinence pad and repositioned the resident. When the resident was repositioned, his/her left buttock was reddened. Interview with CNA #3 at that time revealed the resident was to be turned every 2 hours. c. Observation on 12/20/11 at 10:40 AM with the wound care nurse showed the resident had a reddened area on his/her left buttock that did not resolve 2 hours and 10 minutes after being turned off the affected area. d. Review of the wound assessment document dated 12/20/11 showed the resident had a Stage I pressure ulcer on his/her left buttock that measured 4 cm X 0.5 cm.	F 314	Audits: will be completed by the wound care nurse on all high risk residents and reported at Process Improvement monthly.	2-1-12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	Plan: The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This will be accomplished by:	

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F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and observation, the facility failed to ensure residents received appropriate perineal care for 2 of 4 residents (#48, #54) who were observed while staff provided incontinence care. The findings were: 1. Review of the 12/20/11 admission MDS assessment showed resident #54 needed extensive assistance with toileting and personal hygiene. Observation on 12/19/11 at 11:25 AM showed the resident was incontinent of urine. CNA #2 cleansed the resident's buttocks, but did not cleanse his/her lower abdomen and upper thighs where the urine had come in contact with the skin. 2. Review of 11/29/11 quarterly MDS assessment showed resident #48 was totally dependent on staff for toilet use and hygiene. Observation on 12/19/11 at 5:20 PM showed the resident was incontinent of urine. CNA #2 cleansed the resident's buttocks and the right groin area but did not cleanse the lower abdomen, upper thighs and left groin area where urine had come in contact with the skin. 3. Interview with CNA #2 on 12/19/11 at 6 PM acknowledged residents were to be cleansed in all areas where urine had come in contact with the skin. 4. Interview with the DON on 12/22/11 at 9:55 AM acknowledged staff are to cleanse all areas of the skin that come in contact with urine.	F 315	1. Peri care will be observed on Resident #54 and #48 to ensure they receive appropriate treatment and services to prevent urinary tract infections. Action: 1. Education: peri care education to be provided to nursing staff on January 23. Audits: 10 observations of peri care to be completed monthly and reported at Process Improvement quarterly.	2-1-12
F 387	483.40(c)(1)-(2) FREQUENCY & TIMELINESS	F 387	Tag F387 will begin on the next page	

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F 387 SS=D	Continued From page 10 OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure 2 of 16 (#23 and #26) sample residents were seen by their physician every 30 days after admission for 3 months then every 60 days thereafter. The findings were: Medical record review for resident #23 revealed an admission date of 4/14/10. Further review showed physician progress notes that documented physician visits on 8/20/11 and 12/19/11. Medical record review for resident #26 revealed an admission date of 6/17/11. Further review showed physician progress notes that documented physician visits on 8/20/11 and 12/19/11. Interview on 12/21/11 at 9:50 AM with the DON confirmed 8/20/11 and 12/19/11 were the only two times residents #23 and #26 were seen by their physician.	F 387	Plan: the facility will ensure that every resident is seen by a physician at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. This will be accomplished by: 1. Resident #23 and #26 were seen December 19th by their physician. They both will be seen every 60 days thereafter. Action: Every Goshen Care Center physician will be notified monthly of required 30 or 60 day visits. Audit: Clinical Admin will audit weekly and report at Process Improvement monthly.	2-1-12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	Tag F 431 will begin on the next page	

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F 431	Continued From page 11 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure refrigerated medications were stored separate from food items in 2 of 4 refrigerators where medications were stored. The	F 431	Plan: the facility will ensure that all medication and food items will be stored in separate refrigerators. This will be accomplished by: 1. Mini refrigerators have been added to every hall (200, 300, 400 and 500 hall). Medications have been moved to these refrigerators. Action: 1. Nursing staff educated by January 18th. Audit: Will be conducted by nurse leaders monthly to ensure that all food items and medications are stored in separate refrigerators. This will be reported at Process Improvement quarterly.	1-18-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	12/22/2011

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

(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
F 431	Continued From page 12 findings were: Observation on 12/21/11 at 2:45 PM on the 200 hall showed the refrigerator contained 2 vials of flu vaccine, 2 boxes of Tylenol suppositories, and 2 boxes of Biscodyl suppositories. In addition, there were fruit juices, apple sauce, Ensure, pudding, and Jello in the refrigerator. Further observation at that time on the 400 hall revealed 5 vials of insulin, 1 box of Phenergan suppositories, and 7 vials of flu vaccine stored in the refrigerator with fruit juices and pudding. Telephone interview on 12/22/11 at 8:30 AM with the facility pharmacist confirmed food items and medications are to be stored in separate refrigerators.	F 431	This page left blank intentionally	