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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	01/25/2013

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: CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set CAA: Care Area Assessment RN: Registered Nurse RD: Registered Dietitian MAR: Medication Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and review of resident council meeting minutes, the facility failed to effectively act on grievances related to food and dining for 3 of 3 consecutive months (October, November, December 2012). The findings were: Confidential resident interviews during the survey from 1/22/13 to 1/25/13 revealed five residents	F 244	The facility will listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This will be accomplished by: A.1. Culinary staff will take the temperature of the soup at meal service and serve the soup in metal bowls. Culinary staff will take the temperature of the coffee prior to each meal service. The RD will review the individual snack rotation lists with residents receiving snacks biweekly and update the rotation lists as needed. Culinary staff will serve meals on plates kept warm on the steam table. 2. Resident Council will be tracked through the electronic medical record with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 2/18/2013

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. POC accepted 3/5/13 JChapman RN

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F 244	Continued From page 1 had concerns related to food and dining. The residents were not satisfied with what was being done to ensure food and coffee were served hot. In addition, the residents stated that one to two times per week food substitutions were made to the posted menu. The residents were unhappy with the menus not being followed. The residents stated members from the dietary staff had visited with them regarding these concerns; however, there had not been any effective action taken and the problems continued. The residents reported the problems were ongoing for about six months. The following concerns were identified with the grievance process: a. Review of the October, November, and December 2012 resident council meeting minutes showed 17-19 residents attended these meetings each month. The minutes showed concerns related to food were carried over from month to month without any clear indication as to what had been tried or what the plan was to resolve the concerns. These concerns included the temperature of food and coffee being cold, soups not being available, and the variety of snacks. Within the text of the minutes there were possible solutions to concerns brought up by the residents such as, "...will see about getting the soup into different bowls...try to use the mauve cups for coffee...maybe the residents could remind staff when snacks were repetitive..." However, there lacked any follow up to show if these solutions were tried, actions taken, or any resolution to the issues. In the December 26, 2012 minutes there was a trial mentioned of warm plates. The minutes showed, "[staff name] had warm plates and this was tried for the evening meal and the residents said that their food was nice and warm." Observation of meal service in the main dining	F 244	concerns being submitted by social services or an activities associate directly to management responsible for the area of concern. Management will submit responses through the electronic medical record. Managers or a representative chosen by the manager will attend the Resident Council meeting when they are invited to be there. 3. The posted menus will be reconciled with the cook's menu to assure consistency. The dietary manager will notify the RD of menu changes and the resident menu board will be updated. Menu substitutions will be logged and reviewed by the dietary manager weekly prior to ordering. Items which are consistently unavailable will be replaced on the menu and approved by the RD. B. Resident Council will be presented with the changes to the meal service and the snack rotation on February 26th. C. Audits: 1. The RD manager will perform 3 random meal temperature checks weekly and report to quality improvement quarterly. 2. The Dietary manager will report menu substitutions to quality improvement quarterly. 3. Social Services will monitor resident concerns reported through resident council and report follow up at quality improvement quarterly.	3/7/13

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F 244	Continued From page 2 room on 1/24/13 at 7:30 AM revealed warm plates were not available or used. Interview with server #1 at that time revealed they never used warm plates. b. Interview on 1/25/13 at 9:15 AM with the social worker revealed the process for following up on resident council concerns was the responsibility of the departments involved. The social worker stated there was no formal documentation related to the follow up process other than what may be in the next month's council meeting minutes. c. Interview with the dietary manager and the RD on 1/24/13 at 2:40 PM verified they were aware of food complaints from the residents and one of them, or another dietary representative, attended meetings to try and address the issues. The RD and dietary manager stated they were unaware of any warm plates being used. They acknowledged some food items were no longer available for purchase through their food vendors, items were being substituted, and the menus did not reflect the changed items. During interview on 1/25/13 at 10:20 AM the dietary manager verified issues with the menu and item substitution had been an ongoing issue for about 6 months.	F 244	4. Resident Council concerns and the manager responses will be reviewed as part of a standing agenda item at the Goshen Care Center monthly Operations Meeting.	
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.	F 278	The facility will ensure that MDS assessments will accurately reflect the resident's status. This will be accomplished by: A.1. Resident #47: A correction to the 12/19/12 assessment will be completed by 3/7/13, to accurately reflect the residents current status. The correction will be discussed with the interdisciplinary team prior to submission.	

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3/5/13 ca

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F 278	Continued From page 3 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. 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 MDS assessments were accurately completed for 2 of 16 sample residents (#47, #91). The findings were: 1. Review of the 3/14/12 significant change MDS assessment and CAAs for resident #47 showed the resident understands others and was understood by others. The resident had moderate cognitive impairment due to Alzheimer's Disease, and ADL functional ability was affected by cognitive loss. Review of the 6/14/12 quarterly MDS assessment revealed the resident's cognition was intact, and the 9/17/12 quarterly MDS assessment showed moderate cognitive	F 278	2. Resident #91: The assessment dated 12/21/12 will be discussed with the interdisciplinary team to ensure that the data accurately reflects the residents current status. This will be completed by 3/7/13. B) All residents will have the last MDS assessment reviewed for accuracy of coding for functional limitations to ROM, ADL functional status and section C for cognitive impairment. Completed by 3/7/13. C) Education will be provided to the nursing staff on the importance of accurate charting on functional abilities, and completion of the monthly summary. This will be completed by 3/7/13. D) Audits: 10 random charts will be audited for changes from assessment to assessment and reported at quality improvement quarterly.	3/7/13

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F 278	Continued From page 4 Impairment. Review of the 12/19/12 quarterly MDS assesement showed the resident was assessed as having severe cognitive impairment and an acute mental status change. However, a comparative review of the 9/17/12 and 12/19/12 quarterly MDS assesements showed no significant changes in the amount of ADL assistance that was required from 9/17/12 to 12/19/12. In addition, periodic observations of the resident from 1/22/13 to 1/24/13 revealed the resident understood staff and was understood by staff. Interview on 1/24/13 at 3:50 PM with the social worker and MDS specialist #1 confirmed the 12/19/12 quarterly MDS was inaccurate and needed to be corrected to show the resident did not have severe cognitive impairment and had not experienced an acute mental status change. 2. Review of the 9/20/12 quarterly MDS assesement for resident #91 showed the ADL functional assessment included independent bed mobility, ambulation, eating, and transfers. This review also showed the resident required limited assistance with dressing, toilet use, and personal hygiene, and did not have functional limitations in range of motion. Review of the 12/21/12 annual MDS assessment showed the resident required total assistance with personal hygiene, extensive assistance with dressing and eating and limited assistance with all other ADLs. This review showed functional limitation in range of motion for upper and lower extremities. On 1/24/13 at 3:35 PM MDS specialist #1 was asked about the assessed significant changes in the resident's condition that occurred from 9/20/12 to 12/21/12. At that time she stated the 9/20/12 quarterly MDS assesement was inaccurate.	F 278	Tag F279 begins on the next page	
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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3/5/13 DC

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F 279 SS=D	Continued From page 6 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). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 16 sample residents (#1). The findings were: Medical record review showed resident #1 resided on the secure unit. Review of December 2012 nursing notes showed there were 32 documented instances regarding the resident's behavior. This review showed the behaviors included pacing, rummaging, pushing, grabbing, kicking, hitting, cursing at others and pushing	F 279	The facility will ensure a comprehensive care plan will be developed for each resident. This will be accomplished by: A. Resident #1: A behavior care plan will be completed accurately reflecting the residents current behaviors with appropriate interventions. This will be completed by 3/1/13. B. All residents will be reviewed for current behaviors, a care plan will be completed with appropriate interventions by 3/7/13. C. Education to all clinical staff on behaviors and notification of social services will be completed by 3/7/13. D. Audits: 10 random charts will be audited for behaviors and appropriate interventions, this will be reported at quality improvement quarterly.	3/7/13

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F 279	Continued From page 6 furniture. Additionally, the 1/1/13 to 1/24/13 nursing notes showed there were 17 documented instances regarding the resident's behaviors. This review also revealed the documented behaviors included pacing, rummaging, wandering, pushing items, aggression and hitting "another resident in the back of the head while eating meal." Review of the resident's January 2012 MAR revealed physician orders for risperidone (an antipsychotic) to be administered daily for behavior problems. The following concerns were identified: a. Review of the 4/12/12 significant change MDS assessment and CAAs for the resident revealed behavioral symptoms was triggered for a comprehensive assessment. Further review showed staff made a decision to develop care plan interventions for the resident's behavioral symptoms, specifically wandering. Review of the electronic care plan, last reviewed/updated on 1/9/13, and the previous care plan, last reviewed on 10/12/12, revealed care plan interventions that addressed this resident's behaviors had not been developed. b. In an interview on 1/24/13 at 1:30 PM, MDS specialist #1 verified the care plan did not include interventions for behavioral symptoms.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	The facility will ensure that a comprehensive care plan be developed within 7 days after the completion of the comprehensive assessment; prepared by the interdisciplinary team. This will be accomplished by: A.1. Resident #69: Care plan will be updated to accurately reflect the current condition of the resident's skin and the current treatments being provided. Update	

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CA 3/5/13

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F 280	Continued From page 7 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure care plans were updated to reflect the current status for 3 of 16 sample residents (#32, #41, #69). The findings were: 1. Review of the 3/21/12 annual MDS assessment for resident #69 revealed s/he required extensive assistance for bed mobility, transfers and toilet use. During that assessment period the resident was shown to have "other" skin problems, did not have any pressure ulcers, but was at risk for pressure ulcers. Review of the 9/27/12 care plan showed the resident had potential for impaired skin integrity due to immobility. The 12/13/12 evaluation on this care plan showed the resident had red patches on both buttocks; however, these areas were not open. The following concerns were identified related to updating this resident's skin condition on the care plan: a. Review of the skin assessment dated 12/24/12 at 10:25 PM showed the resident's skin	F 280	to be completed and discussed with the interdisciplinary team by 3/7/13 2. Resident #41: Care plan will be updated to accurately reflect the surgical wound care currently being provided. Update to be completed and discussed with the interdisciplinary team by 3/7/13. 3. Resident #32: Care plan will be updated to reflect resident specific interventions or approaches for behaviors. Update to be completed and discussed with the interdisciplinary team by 3/7/13. B) 1. All residents identified with skin issues will have a care plan review to ensure that the care plan accurately reflects the skin issues identified and skin treatments will be added to the care plan at the time. Review and updates to be completed by 3/7/13. 2. All residents identified to have behaviors will have a care plan review to ensure that their care plan accurately reflects resident specific interventions or approaches. Review and updates to be completed by 3/7/13. C) 1. Education to be provided to all clinical staff to initiate or update the care plan when a change is identified in a resident's skin integrity and treatment is started. Education to be completed by 3/7/13. 2. Education to social services and activities specialist to update their respective care plans to reflect current	

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F 280	Continued From page 8 was split in the left groin area. Continued review showed on 1/3/13 at 12:58 AM there was a late entry for 1/2/13 showing the resident had an open area on the right buttock and a new area of split skin in the groin area on the right side. On 1/5/13 at 4:12 AM there was a nurse's note that showed the open areas on the resident's abdomen were getting smaller. b. Observation on 1/24/13 at 8:10 AM revealed LPN #3 completed a skin assessment for resident #69. At that time, an open three centimeter skin split area on the resident's right groin was observed. c. Interview with the DON on 1/25/13 at 8:10 AM verified the care plan did not reflect the current condition of the resident's skin, and the current treatments. 2. Review of the 11/16/12 admission MDS assessment for resident #41 showed s/he had diagnoses including diabetes mellitus. The resident was not at risk for pressure ulcers; however, s/he was shown to have "other" skin problems. Review of the 11/21/12 care plan for skin problems showed the resident had open lesions on his/her toes on the left foot. Review of nursing notes showed on 1/9/13 at 4:44 PM the resident had surgical wounds from having the left foot, second toes amputated due to diabetic ulcers. Surgical wound care continued to be documented as of 1/24/13; however, the resident's care plan was not updated to reflect these changes. Interview with the DON on 1/25/13 at 8:10 AM verified the care plan should reflect the accurate status of the resident. 3. Review of the 12/7/12 quarterly MDS assessment for resident #32 showed s/he	F 280	resident specific interventions or approaches to behaviors. Education to be completed by 3/7/13. D) Audits: 10 random chart audits to be completed monthly to ensure care plans include behavior interventions, reported quarterly at quality improvement. 10 random chart audits to be completed monthly to ensure care plans include any skin issues and appropriate treatment, reported quarterly at quality improvement.	3/7/13

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F 280	Continued From page 9 wandered daily. Review of the 12/8/12 10:49 PM nurse's note showed the resident wandered and wore a wanderguard device to prevent elopement. The note further showed the cause of the behavior was the resident missed his/her spouse. Review of the behavior care plan dated 12/10/12 showed the resident had attempted to leave the facility. The care plan failed to develop approaches. The approaches showed, "Identify unique characteristics that may be used to reduce agitation (eg: work history, hobbies, sense of identity)."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure pain medication was provided based on the results of the assessment for 1 of 6 sample residents (#85) treated for intermittent pain. The findings were: Review of the 11/8/12 hospital discharge summary for resident #85 showed after s/he left the hospital, the resident was admitted the same day to the care center. The discharge diagnoses included recurrent bilateral pleural effusion, pulmonary embolus with hemothorax with	F 309	The facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This will be accomplished by: A. Resident #85 will have a comprehensive pain assessment completed by 3/7/13. Recommendations will be sent to the primary care physician for appropriate pain medication to be administered. The care plan will be updated with appropriate pain interventions by 3/7/13. B. All residents that have received a PRN pain medication in the last 30 days will have an initial audit completed to ensure pain assessment was completed and appropriate PRN pain medication was given, per physician order. This will be completed by 3/7/13.	

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F 309	Continued From page 10 decision not to treat with anticoagulants, hematoma to left buttock post fall, and a healing pressure ulcer to the coccyx area. Review of the 11/19/12 pain care area assessment showed the resident had frequent pain generally described as "all over." Review of the resident care plan dated 11/20/12 showed the resident's pain was treated with PRN (as needed) pain medications based on assessed physical symptoms using a verbal pain assessment scale. Review of the physician orders showed several 11/8/12 physician admission orders for pain medications: Tylenol 325 mg 1 tablet every 4 hours PRN; Tylenol 325 mg 2 tablets every 4 hours PRN; Ibuprofen 200 mg tablet, 2 tablets every 4 hours PRN; Ibuprofen 200 mg tablet, 3 tablets every 4 hours PRN; Tylenol 500 mg, 1 tablet every 4 hours PRN; Tylenol 500 mg tablet, 2 tablets every 4 hours PRN; and Norco 5 mg-325 mg tablet, 1 tablet every 4 hours PRN for moderate to moderately severe pain. The following concerns were identified with the assessments and treatments of this resident's pain: a. Review of the December 2012 pain assessments and MAR showed the resident received the narcotic PRN pain medication Norco 38 times. The pain medication was administered to the resident when the pain levels were reported anywhere from 0 to 8 on a verbal pain scale of 1-10 with 10 being the worst pain. The resident was administered Norco on 12/27/12 at 8:43 PM when the pain level prior to medication was shown to be zero. In addition, the resident was administered the Norco for pain rated as a 2 out of 10 on 12/23/12 at 7:52 PM, 12/26/12 at 8:09 PM, 12/29/12 at 8:20 PM, 12/30/12 at 3:37 PM and 8:16 PM. b. Review of the 1/1/13-1/23/13 pain	F 309	C. Education will be provided to the nursing staff on pain assessment. The "pain scale numbers" will be added to the medication administration record, per the physician order, to be correlated with the appropriate medication to be administered. This will be completed by 3/7/13. D. Audit: 10 random charts will be audited monthly to ensure appropriate pain assessment and medication was given. Reported to quality improvement quarterly.	3/7/13

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	53A049	A. BUILDING _____ B. WING _____	01/25/2013

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F 309	Continued From page 11 assessments and MAR showed the resident received the narcotic pain medication Norco 23 times. The medication was administered for pain rated as a 2 out of 10 on 1/7/13 at 8:25 PM, 1/13/13 at 8:31 PM, and 1/14/13 at 8:28 PM. The Norco was administered for pain rated as a 3 out of 10 on 1/2/13 at 8:08 PM, 1/3/13 at 7:57 PM, 1/11/13 at 8:16 PM, 1/12/13 at 8:09 PM, 1/16/13 at 8:10 PM, and 1/23/13 at 8:31 PM. c. Further review of these pain assessments and the care plan failed to show the resident's tolerable level of pain. In addition, the assessments and care plan failed to define a number on the pain scale which correlated with "moderate to moderately severe pain" as a parameter for use in the order for the Norco. d. Interview with the DON on 1/25/13 at 8:10 AM verified the pain assessments were intended to show why an intervention was provided. In these cases when the pain rating was low, she stated administration of a different PRN pain medication may have been more appropriate.	F 309		
F 329 S9=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329	The facility will ensure that each resident's drug regimen is free from unnecessary drugs. The facility will accomplish this by; A. Resident #33: Risk / benefit information for Lunesta will be documented by the physician, completed by February 28, 2013. B. Review of all residents on Lunestra will be done to verify documentation is complete. Completed by February 28, 2013.	

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CE 3/5/13

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F 329	Continued From page 12 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the drug regime for 1 of 16 sample residents (#33) was free of unnecessary medications. The findings were: Review of the 8/9/11 physician's admission orders showed resident #33 had an order for Lunesta 3 mg at bedtime PRN (as needed) for insomnia. Review of the resident's MAR for November 2012, December 2012, and January 2013 showed s/he received Lunesta nightly. Review of the resident's 11/20/12 psychoactive medication recommendation showed the consulting pharmacist documented under recommendations, "[resident's gender] continues to require this frequently. Request an evaluation of risk/benefit-need to change to something else." The physician signed the form on 11/20/12 after checking a box for "Accept recommendation for New medication or Gradual Dose Reduction (Risk and benefits completed above)." However, the area on the form to complete the risks versus	F 329	C. Log of Comprehensive Resident Team recommendations for tapering of Lunesta will be maintained by pharmacy with verification that the documentation has been completed within 30 days. D. Percentage of completed forms will be reported to the quality improvement committee quarterly.	2/28/13

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F 329	Continued From page 13 the benefits was left blank. Review on 1/23/13 of the physician's orders showed no changes were made to the Lunesta order, and the resident continued to receive Lunesta 3 mg nightly. Review at that time of the nursing notes for 1/2/13, 1/3/13, 1/8/13, 1/12/13, 1/13/13, 1/16/13, 1/17/13, and 1/18/13 showed the medication was ineffective. During an interview with the DON on 1/23/13 at 4:30 PM she stated the facility failed to complete an assessment of the resident's insomnia and the continued use of the medication.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to demonstrate a medication error rate of less than five percent. Three medication errors were observed out of 50 opportunities, resulting in a medication error rate of six percent. The findings were: 1. During the medication pass on 1/24/13, LPN #2 was observed administering alendronate sodium-cholecalciferol (medication for the treatment of osteoporosis) 70 mg to two residents (#62 and #37) at 7:17 AM and 7:20 AM, respectively. The residents were awakened from sleep, encouraged to sit up to take the medication; then instructed to lay down in bed. In an interview on 1/25/13 at 8:25 AM pharmacist #1	F 332	The facility will ensure that it is free of medication error rates of 5% or greater. This will be accomplished by: A. Resident #62 and #37 had no ill effect from receiving alendronate and then proceeded to lie down in bed. Resident #49 had no ill effect from the missed dose of diclofenac sodium. B. A safety alert will be added to all resident's medication administration record that are currently receiving alendronate. C. Education provided to nursing staff on the safe administration practices for alendronate. Nursing staff will be educated on medication replacement if missing dose. Education will be completed by 3/7/13 D. Audit: 10 medication administration passes will be monitored monthly and reported to quality improvement quarterly.	3/7/13

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F 332	Continued From page 14 verified safe administration practices for alendronate sodium-cholecalciferol required instructions for the resident to remain upright for at least 30 minutes after receiving the medication. Failure to have these residents remain upright constituted two of three errors that occurred with this medication pass. According to PDR Nurse's Drug Handbook, 2013 Edition, page 433, "Instruct to take medication with plain water the first thing upon arising for the day at least 30 minutes before the first food, beverage, or medication, and to swallow each tab with a full glass of water (6-8 oz.). Instruct to avoid chewing or sucking on tab, taking at hs [bed time] or before arising for the day, and lying down for at least 30 minutes following administration and until after first food of the day." 2. During the medication pass on 1/24/13 at 7:32 AM, LPN #2 was observed pouring the following medications: donepezil 5 mg, memantine HCl 10 mg, diclofenac sodium 100 mg, citalopram 10 mg and furosemide 40 mg. These medications were handed to resident #49 in a plastic medication cup. The resident's hand jerked, and one pill was observed by the surveyor falling to the floor of the resident's room. The following concerns were identified: a. LPN #2 was unaware of the pill falling to the floor until alerted by the surveyor. b. During an interview with the LPN during the medication pass at 7:32 AM she stated she would take the pill to the pharmacy to have it identified and replaced. She further stated she was unable to make a visual comparison to identify which of the five dispensed medications had fallen to the floor because the medication cartridges were empty.	F 332	This page left blank intentionally	

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F 332	Continued From page 15 c. Interview with pharmacist #2 on 1/24/13 at 4:05 PM revealed the pharmacy department had no knowledge of a medication falling to the floor and needing to be replaced. d. When LPN #2 was interviewed regarding the missed medication on 1/24/13 at 4:15 PM, she stated that she had gotten "really busy" and did not do anything about the missed medication. e. In an interview on 1/25/13 at 8:33 AM, the DON stated the medication was omitted due to the facility's complex system for obtaining replacement medications from the pharmacy. The omitted medication was the third error with this medication pass.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure clean and sanitary conditions were met related to food equipment in 2 of 3 kitchen areas (the secure unit kitchen and the beverage station in the main dining room). In addition, the facility failed to ensure 3 of 3 ice machines were clean and sanitary and had filters	F 371	The facility will ensure that the food is procured from sources approved or considered satisfactory by the Federal, State, or local authorities and they will store, prepare, distribute and serve food under sanitary conditions. This will be done by the following methods: A. The juice guns and holder will be wiped down after every meal and soaked after each supper meal daily. B. The vents will now be cleaned in the secure unit on a biweekly basis starting in February. C. The culinary staff will be educated on the cleaning changes immediately and again at the monthly staff meeting on February 19th. D. The juice guns and the vents will be monitored for completion of tasks on a weekly basis.	

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F 371	Continued From page 16 changed when needed. The findings were: 1. Observation in the secure unit kitchen area on 1/22/13 at 10:45 AM and on 1/24/13 at 7:38 AM showed a juice machine with a hand held dispenser. The hand held dispenser was used to dispense thickened juices and water. The dispenser was visibly sticky with juice stored in the drip pan with the nozzle sitting in the dripped juice. On 1/24/13 at 2:25 PM the RD and dietary manager were interviewed and observed the juice dispenser. At that time they verified it needed to be cleaned more frequently to prevent the build-up. Observation on 1/24/13 at 7:57 AM showed the same style of juice dispenser was located in the main dining room beverage area. The dispenser was not clean, was sticky and there was an accumulation in the pan of dripped juice. During the 1/24/13 at 2:25 PM interview and observation with the RD and dietary manager, they also verified this juice machine was in need of more frequent cleaning. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation of the secure unit kitchen on 1/22/13 at 10:45 AM, and on 1/24/13 at 7:38 AM showed the hood vents above the the range/oven unit had a visible accumulation of dust and grease. Interview with the RD on 1/24/13 at 2:25 PM revealed the removable hood vents were expected to be cleaned on a weekly basis. She thought they had been due to be cleaned that Monday (1/21/13); however, interview with cook	F 371	E. The tasks will be reported to PI on a quarterly basis by the culinary manger. F. The Facility EVS and Culinary staff will perform daily cleaning and sanitizing of the outer surface of the icemakers to ensure clean and sanitary conditions. Start date: 02/12/13. G.The Culinary Manager and the EVS Manager will monitor the outside cleaning of the ice machines on a weekly basis. H. The cleaning and sanitizing of the ice machines will be reported to PI quarterly by the Culinary Manager. I. The PM of each ice machine will be complete on a quarterly basis by the maintenance department. The PMs for these ice machines were completed on the Icemaker in the kitchen on the secure unit on 01/25/13, the main kitchen on 02/11/13, and for the GCC nutrition center on 2/13/13. J. The PM cleaning of the ice machines will be monitored by the Maintenance Manger on a quarterly basis and reported to PI on a quarterly basis.	2/19/13

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DO 3/6/13

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F 371	Continued From page 17 #2 on 1/24/13 at 3:15 PM revealed she had cleaned them about 2 or three weeks ago, and they were due to be cleaned again. According to Food Code 2009, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch... (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation during a tour with the maintenance director on 1/25/13 from 9 AM through 9:35 AM showed three ice machines which provided ice for residents were located in the main kitchen, the long term care nutrition center, and the kitchen in the secure unit. The following concerns were identified: a. All three ice machines had a visible whitish buildup of mineral deposits located on the outside surfaces of the machines. In addition, all three ice machines had an accumulation of dust on the air vents. Each ice machine had a water filter encased in a clear plastic container located along the water pipes just before the water entered the ice machine. Each filter was dirty with accumulated dirt and was not dated as to when they were changed. b. During an interview with the maintenance director, he stated the mineral deposits on the outside of each ice machine were the result of water leakage at the pipe entrance to each machine. He further stated the facility had failed to identify this issue to schedule a repair time. He also confirmed the three water filters were dirty, not dated as to when they were changed, and needed to be changed. The maintenance director then provided a maintenance schedule for all three machines.	F 371	This page left blank intentionally	

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F 371	Continued From page 18 c. Review of the PM (preventive maintenance) schedule required a minimum of every three months to perform PM on each machine. This schedule required the following maintenance: "1. Run ice cleaner thru machine for 20 to 30 minutes, 2. Remove all ice from bin and clean unit, 3. Replace water filters and date, 4. Clean coils, and 5. Check all water and drain lines." Review of the PM schedules showed the PM, including the water filter, was not done for the ice machine in the secure unit since 8/30/12 (148 days). Although all 3 machines appeared to be unsanitary and in need of filter changes, the other two ice machines documentation showed the PM was completed on 12/17/12 and 12/18/12.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure that an identified medication irregularity was addressed for 1 of 16 sample residents (#33). In addition, the facility failed to ensure that accepted medication administration practices were followed	F 428	The facility will ensure that the drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. The pharmacist will report any irregularities to the attending physician and the director of nursing and these reports must be acted upon. This will be accomplished by: A. 1. Resident #33: The primary care physician to complete documentation regarding irregularity; to be completed by Feb 28, 2013. The pharmacists will verify that all pharmacy consultant recommendations sent to physicians as of Feb. 15 have been responded to by the physician. To be completed by February 28, 2013	2/28/13

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F 428	Continued From page 19 during administration of medications for 2 non-sample residents (#37, #62). The findings were: 1. Review of the 3/9/11 physician's admission orders showed resident #33 had an order for Lunesta 3 mg at bedtime PRN (as needed) for insomnia. Review of the resident's 11/20/12 psychoactive medication recommendation showed the consulting pharmacist documented a recommendation to change the medication. The physician signed the form on 11/20/12, but left all other areas blank. Review on 1/23/13 of the physician's orders showed the physician had not changed the medication. During an interview with pharmacist #2 on 1/24/13 at 10 AM, she stated a committee met weekly to discuss medication issues. She stated the procedure was for the pharmacist to ensure identified irregularities were addressed. However, she acknowledged the facility failed to do so for resident #33's Lunesta order. 2. According to the January 2013 MAR for resident #62 the physician ordered monthly doses of alendronate sodium-cholecalciferol (medication for treatment of osteoporosis). Review of the pharmacy consultant recommendation dated 11/20/12 revealed the pharmacist recommended taking the medication on an empty stomach with a full glass of water and at least 30 minutes before the first food, drink, or drugs of the day. Further review revealed the pharmacist failed to include recommendations for remaining upright after taking the medication. On 1/24/13 at 7:17 AM LPN #2 was observed administering the medication and directing the resident to lie in bed after swallowing the medication.	F 428	2. Resident #62 and #37: the medication administration record will be updated to reflect complete administration guidelines. This will be completed by February 15, 2013 B. 1. A Report will be run listing all residents with orders for Fosamax (alendronate). The eMAR will be updated to reflect complete administration guidelines. Completed by: February 28th. 2. Starting Feb. 15th a log of all consultant recommendations will be maintained by pharmacy with a monthly audit to verify the recommendation has been responded to by the physician. C. Education for nursing staff regarding administration guidelines for Fosamax (alendronate) will take place at the next Nursing Meeting education to be completed by 3/7/13. . The nursing staff will be educated annually on the administration guidelines for those medications. D. Audit 10 charts per month to verify residents on the identified medications have correct administration guidelines on the eMAR. Reported quarterly to quality improvement. The log of all consultant recommendations with appropriate response from the physician will be reported to quality improvement quarterly.	2/15/13 3/7/13

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F 428	Continued From page 20 3. According to the January 2013 MAR for resident #37 the physician ordered monthly doses of alendronate sodium-cholecalciferol (medication for treatment of osteoporosis). Review of the pharmacy consultant recommendation dated 11/16/12 revealed the pharmacist recommended taking the medication on an empty stomach with a full glass of water and at least 30 minutes before the first food, drink, or drugs of the day. Further review revealed the pharmacist failed to include recommendations for remaining upright after taking the medication. On 1/24/13 at 7:20 AM LPN #2 was observed administering the medication and directing the resident to lie in bed after swallowing the medication. 4. Interview with pharmacist #1 on 1/25/13 at 8:25 AM revealed the pharmacist consultant recommendations should have included information about ensuring the resident remained upright for 30 minutes after taking alendronate sodium-cholecalciferol. He further stated this safe medication administration practice prevents irritation to the esophagus (swallowing tube).	F 428		
F 431 SS=D	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 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	F 431	The facility will store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. This will be accomplished by: A. No ill effect noted from the lack of temperature logs, all food has been removed from all medication refrigerators.	

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	53A049	A. BUILDING _____ B. WING _____	01/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2000 LARAMIE STREET TORRINGTON, WY 82240

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F 431	Continued From page 21 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, review of temperature logs, and staff interview, the facility failed to consistently implement their system for monitoring medication refrigerator temperature for 2 of 4 medication room refrigerators. Additionally, the facility failed to separate food from medications in 1 of 4 medication room refrigerators. The findings were: 1. During an interview on 1/26/13 at 9:10 AM, RN #1 stated the facility's system for monitoring the medication refrigerator temperatures was to	F 431	B. Daily temperature checks will be added to the daily task list and signed off by the appropriate nurse. C. Education will be provided to nursing staff on required daily temperature checks on all medication refrigerators. Education will be provided to nursing staff on inability to co-mingle food and medications. Education will be completed by 3/7/13. D. Audit: temperature logs will be audited monthly and reported quarterly at quality improvement. 4 spot checks per month to ensure there is no co-mingling of food and medication and reported at quality improvement quarterly	3/7/13

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F 431	Continued From page 22 check it daily and record the temperature in the temperature log book. She further stated "there should be a signature every day with the temperature." During an interview on 1/25/13 at 9:20 AM LPN #1 confirmed the facility's system for ensuring safe medication storage in refrigerators was to complete the daily temperature log. The following concerns were identified: a. The 400 hall medication room refrigerator was observed on 1/25/13 at 9:10 AM. At that time opened and unopened medications were stored in the refrigerator and the temperature was within normal limits. However, review of the temperature logs showed staff failed to consistently monitor the temperatures. Review of the January 2013 logs showed temperatures were not recorded for 19 of 25 days in the month. Review of the December 2012 log revealed that temperatures had not been recorded on 14 of 31 days. b. The 500 hall medication room refrigerator was observed on 1/25/13 at 9:20 AM. At that time opened and unopened medications were stored in the refrigerator and the temperature was within normal limits. However, review of the logs showed staff failed to consistently monitor the temperatures. Review of the January 2013 logs revealed temperatures for the refrigerator had been not been recorded 14 of 25 days. Staff was unable to locate refrigerator temperature logs for the 500 hall medication room refrigerator for any months prior to January 2013. c. During interviews with RN #1 on 1/25/13 at 9:10 AM, and LPN#1 on 1/25/13 at 9:20 AM, both confirmed the temperature logs were incomplete. 2. Medications co-mingled with food were observed in the 500 hall medication room	F 431	This page left blank intentionally	

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	53A049	A. BUILDING _____ B. WING _____	01/26/2013

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GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 431	Continued From page 23 refrigerator on 1/25/12 at 9:20 AM. The observed contents in the refrigerator included the following: an opened bottle of lorazepam liquid, unopened Lantus insulin, opened box of Dulcolax suppositories, 3 unopened containers of pudding, and 2 unopened containers of yogurt. During an interview on 1/26/13 at 9:20, LPN #1 confirmed that the refrigerator was to be used only for the storage of medications.	F 431		
F 514 SS=D	483.76(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure accurate and complete medical records were maintained for 2 of 16 sample residents (#33, #47). The findings were: 1. Review of the December 2012 and 1/1/13-1/24/13 MAR for resident #47 showed a physician's order for DuoNeb (respiratory	F 514	The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This will be accomplished by: A. Resident #47: the primary care physician has been notified of the omissions, and no ill effect has been noted from the omissions. Resident #33: the entry order of Lunesta has been fixed in accordance to the physician order written on 3/9/11 for 3mg. B. All medication administration records will be audited for the last 30 days to ensure medications have not been omitted. All medication administration records will be reviewed to ensure accurate order entry by 3/7/13. C. Education provided to all nursing staff on facility standards for documenting medication administration. Education provided on order entry of medications. Education to be completed by 3/7/13.	

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F 514	Continued From page 24 medication) 0.6 mg/3ml - 2.5 mg/3 ml to be administered four times a day at 7 AM, 12 PM, 7 PM, and 12 AM, and a physician's order for Norco (narcotic pain medication) 5 mg/325 mg to be administered four times daily at 7 AM, 12 PM, 7 PM, and 12 AM. The following concerns were identified: a. Review of the December MAR showed 19 instances where there was no documentation of DuoNeb administration. These omissions occurred on 12/1/12 at 7 PM, 12/2/12 at 12 AM, 12/3/12 at 7 PM, 12/8/12 at 7 PM, 12/9/12 at 7 PM, 12/10/12 at 12 AM, 12/13/12 at 7 PM, 12/14/12 at 7 PM, 12/15/12 at 12 AM, 12/17/12 at 7 PM, 121812 at 7 PM, 12/22/12 at 7 PM, 12/23/12 at 7 PM, 12/26/12 at 12 AM, 12/28/12 at 12 AM and 7 AM, 12/30/12 at 12 AM and 7 PM, and 12/31/12 at 12 AM. Review of the MAR for the period from 1/1/13-1/24/13 revealed another ten omissions, occurring on 1/2/13 at 7 PM, 1/10/13 at 12 AM, 1/11/13 at 7 PM, 1/15/13 at 12 AM and 7 PM, 1/18/13 at 12 PM, 1/19/13 at 12 AM, 1/22/13 at 12 PM, and 1/24/13 at 12 PM and 7 PM. b. Review of the December MAR showed 17 instances where there was no documentation of Norco administration. These omissions occurred on 12/1/12 at 7 PM, 12/3/12 at 7 PM, 12/8/12 at 7 PM, 12/9/12 at 7 PM, 12/10/12 at 12 AM, 12/13/12 at 7 PM, 12/14/12 at 7 PM, 12/15/12 at 12 AM, 12/17/12 at 7 PM, 12/18/12 at 7 PM, 12/22/12 at 7 PM, 12/23/12 at 7 PM, 12/28/12 at 12 AM and 7 AM, 12/30/12 at 12 AM and 7 PM, and 12/31/12 at 12 AM. Review of the 1/1/13-1/24/13 MAR revealed an additional 10 omissions. These omissions occurred on 1/2/13 at 7 PM, 1/10/13 at 12 AM, 1/11/13 at 7 PM, 1/16/13 at 12 AM and 7 PM, 1/16/13 at 12 PM,	F 514	D. Audit: 10 random charts will be audited monthly for accurate order entry and reported to quality improvement quarterly. 10 medication administration records will be audited monthly to ensure completion of documentation, reported quarterly at quality improvement.	3/7/13

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F 514	Continued From page 25 1/19/13 at 12 PM, 1/22/13 at 12 PM, and 1/24/13 at 12 PM and 7 PM. c. During an interview on 1/24/13 at 2:20 PM, the DON confirmed that the "spaces" on the MAR were blank and there was no documentation as to whether the medication was administered or not. The DON further stated the nurse administering the medication should have documented it on the MAR in accordance with the facility's standards for documenting medication administration. 2. Review of the 3/9/11 physician's admission orders for resident #33 showed s/he had an order for Lunesta 3 mg at bedtime PRN (as needed) for insomnia. Review of the November 2012, December 2012, and January 2013 MAR showed a 10/19/12 order for Lunesta 1 mg at bedtime as needed (PRN) for insomnia. The review showed the resident received the medication nightly. Review of the entire medical record showed the resident had only one order for Lunesta, which was the physician's order of 3/9/11. During an interview with the DON on 1/23/13 at 4:45 PM, she went to the PYXIS Machine (automated machine for dispensing medications) with the surveyor. She entered the machine and found only Lunesta 3 mg was available and signed out for resident #33. The DON confirmed that staff had created an input error on 10/19/12, which incorrectly changed the physician's order on the MAR to read Lunesta 1 mg, rather than the 3 mg that was ordered and being administered.	F 514	This page left blank intentionally	