STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1998. The building was equipped with a supervised automatic wet sprinkler system and a dry branch with an addressable fire alarm system. The facility had a capacity of 75 certified Medicaid beds with a census of 63 residents.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The center activities corridor door glass vision panel was fixed so that the frame of the window is now equipped with a complete frame. Completion date: January 9, 2012 This will be monitored by monthly environment of care walkthroughs and reported quarterly to Safety Committee.	1-9-12

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

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.

for Administrator w/ Natalie Kordell, MHA, DN

1/27/12

WY Dept of Health
JAN 25 2012
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/20/2011

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
K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation of the center activities corridor door on 12/19/11 at 2:28 PM showed the glass vision panel was not equipped with a complete frame. The top and both sides of the window frame were missing with only the bottom section intact. At the time of the observation the maintenance director could not explain why the frame had not been noticed and repaired during the quarterly inspections. He also reported that the housekeeping staff should have reported any damaged to corridor doors. Reference: NFPA 101, 2000 Edition; 19.3.6.3.8 Fixed fire window assemblies in accordance with 8.2.3.2.2 shall be permitted in corridor doors. Exception: There shall be no restrictions in area and fire resistance of glass and frames in smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two	K 025	Fireproof doors have been ordered (12/23/11) and will be installed above the 200 and 400 hall in the attic spaces where the 2 by 4 foot openings were cut.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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

1/27/12

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 5 smoke barriers were smoke resistant. The findings were: Observation on 12/20/11 between 9 AM and 10 AM showed 2 feet by 4 foot access door openings had been cut into the 200 and 400 hall attic smoke barrier walls. Further observation showed the openings were not equipped with doors to provide smoke resistant barriers. At 9:17 AM the maintenance director could not explain why the attic smoke barrier walls were not routinely inspected.	K 025	Completion Date: February 5, 2012 Attic spaces will be monitored through the use of our, "Above the Ceiling Work Permit" Policy, and quarterly for each compartment by the Maintenance Staff. Findings will be reported at Safety Committee meeting quarterly.	2-5-12
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 latches on the smoke barrier door on 200 Hall needed screws and those were replaced and the door latches. This will be monitored and tested monthly with a preventative maintenance schedule. Any repairs will be made immediately. This will be reported quarterly to the Safety Committee. Completion Date: December 21, 2011	12-21-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 027	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 of 5 smoke barrier double doors were smoke resistant. The findings were: Observation of the 200 hall double smoke barrier doors on 12/19/11 at 3:47 PM showed both of the doors were equipped with self-closing devices. Further observation showed one of the doors was not able to fully latch into the door frame with three attempts. At the time of the observation the maintenance director could not explain why the door had not been noticed and repaired during the quarterly inspections.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were:	K 029	This 1-inch gap was sealed with fire-rated penetrating caulking to the gap. Completion Date: December 21, 2011 The facility will ensure compliance with this standard by enforcing the use of the "Above the Ceiling Work Permit" Policy and these areas will be inspected quarterly by Maintenance Staff. Findings will be reported to Safety Committee quarterly.	12-21-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 029	Continued From page 4 Observation of the general storage room on 12/19/11 at 1:56 PM showed a cable pass through had a 1-inch unsealed gap. At the time of the observation the maintenance director reported the information technology staff have been trained on sealing gaps after completing work. He could not explain why the gap had not been noticed and filled during the quarterly inspections.	K 029		
K 060 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under 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 This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure staff members were familiar with fire drill procedures on 1 of 2 shifts. The findings were: Observation of the fire drill on 12/20/11 at 10:49 AM showed the maintenance director placed a red flag with the word FIRE written across it, in resident room #407 and activated the nurse call system. The first responder was a certified nurses' assistant (CNA #1) who left the room without taking any action and asked a licensed	K 060	The facility will utilize a strobe with the FIRE sign to alert staff of the drill. More training will be provided all Goshen Care Center staff during the January staff meetings on Code Red procedure. Completion Date: February 5, 2012 This will be monitored through fire drills assessments and follow-up with the staff. Education opportunities will be discussed monthly at Safety Committee.	2-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 050	Continued From page 5 practical nurse (LPN #1) to enter the room. LPN #1 saw the sign, left the room without calling out a code phase and did not close the corridor door. LPN #1 activated the fire alarm pull station at the 400 hall nurses' station and informed the operator there was a Code Red on the 400 hall. The overhead page stated "Code Red 400 Hall Nurses' Station" three times. When the facility staff arrived they closed all of the corridor doors and assumed the fire was at the 400 hall nurses' station. The all clear was announced over the intercom system at 10:52 AM. At 10:55 AM CNA #1 reported she did not see the fire flag. At the same interview LPN #1 reported she was aware the "Code Red" procedure stated the phrase Code Red and the exact location was supposed to be called out three times upon discovering a fire. She also reported the corridor door was supposed to be closed after leaving the room and the operator is supposed to be told the exact location of the fire, as stated in the Code Red Procedure.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 062	1. The facility requested the Central Station Certification from Neco and the Central Station Certification is posted. Completion Date: January 5, 2012 The facility will ensure compliance with this regulation by contacting NECO each year in March and requesting the Central Station Certification and posting it within 36 inches of the fire panel. This will be monitored annually by environment of care walkthrough and reported annually to Safety Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the central station certificate was posted and failed to ensure the fire alarm system was activated during 4 of the past 12 months. The findings were: 1. Observation of the fire alarm control panel on 12/20/11 at 8:58 AM showed the central station certificate was not posted within 36 inches of the panel. At the time of the observation the maintenance director reported he was unaware of the aforementioned requirement. He also was unable to provide a central station certificate to review to ensure it was current. 2. Review of the fire alarm system testing records showed the system was not activated during the months of May, July, August and November of 2011. On 12/20/11 at 10:40 AM the maintenance director reported he was unaware the fire alarm system was required to be activated on a monthly basis. Reference: NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition; 6-2.2.3.1.1 Fire alarm systems providing services that complies with all the requirements of this code shall be certified by the organization that has listed the central station, and a document attesting to this certification shall be located on or within 36 in. of the fire alarm system control unit or, if no control unit exists, on or within 36 in. of a fire alarm system component. Table 7-3.2 Testing Frequencies. 23. Receivers,.....monthly	K 052	2. The fire alarm system was not activated in August 2011. Neco provided documentation records of activation showing all systems were activated, with the exception of the month of August, 2011. In the future the maintenance director will have records available to show activations of all the systems. These records will be reported annually to the Safety Committee by the maintenance director.	1-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure complete sprinkler coverage in 1 of 4 smoke compartments. The findings were: Observation of bathtique #534 on 12/19/11 at 5 PM showed a clean linen closet was stored in the alcove to the right of the bath tub, measuring 2 feet by 3 feet and 6 feet tall. Further observation showed the single sprinkler head in the room did not provide coverage for the alcove. The lack of sprinkler coverage was confirmed by the administrator and maintenance director. At the time of the observation the maintenance director reported the last quarterly inspection (9/26/11) did not indicate a lack of sprinkler coverage. Reference: NFPA 101, 2000 Edition, 19.3.5.1, 9.7.1.1, NFPA	K 056	The original plans called for two sprinklers to be installed in the bathtiques (Room #534) to provide adequate sprinkler coverage and only one was installed. Phoenix Fire will install the missing sprinkler in both bathtiques in the Alzheimer's Unit. Completion Date: February 5, 2012 The Maintenance Staff will monitor completion of the sprinklers in these two areas and report to the Safety Committee annually.	2-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEN 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
K 056	Continued From page 8 13, 1989 Edition; 5-1.1 The requirements for spacing, location, and position of sprinklers are based on the following principles: 1) Sprinklers installed throughout the premises 2) Sprinkler located so as not to exceed maximum protection area per sprinkler 3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the spare sprinkler cabinet had two spare heads for each type installed. The findings were: Observation of the spare sprinkler cabinet on 12/19/11 at 2:51 PM showed there were no spare 165 degree sidewall sprinkler heads to replace the head installed above the 400 hall exit door. At the time of the observation the maintenance director reported he relied upon the sprinkler contractor to provide all of the needed sprinkler heads. Review of the last quarterly sprinkler inspection report (9/26/11) showed the missing sprinkler heads were not noted. Reference:	K 052	Facility will have spare 165 degree sidewall sprinklers specially made by Phoenix Fire for the exit areas and will store them in the spare sprinkler cabinet. The wrench has been added to the cabinet. Completion date: February 5, 2012 This will be monitored by Maintenance Staff through quarterly preventative maintenance checks and reported quarterly to the Safety Committee.	2-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 062	Continued From page 9 NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5, NFPA 25, 1999 Edition; 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit. 2-4.1.5 The stock of Spare Sprinklers shall be as follows: (a) ...Under 300 sprinklers - no fewer than 6 sprinklers (b) ...300-1000 sprinklers - no fewer than 12 sprinklers.... 2-4.1.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.	K 062		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.6.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure smoke dampers were	K 067	The smoke damper was replaced by a vendor on January 6, 2012. Completion Date: January 6, 2012 Maintenance Staff will monitor smoke dampers through preventative maintenance checks on a quarterly basis and reported to the Safety Committee annually.	1-6-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 067	Continued From page 10 maintained in 1 of 6 smoke compartments. The findings were: Observation of the 400 hall on 12/20/11 at 9:28 AM showed the electrical wires to the smoke damper near resident room #415 were capped with wire nuts. At the time of the observation the maintenance director was unaware when or why the damper was disconnected. Review of the last fire alarm testing records (3/31/11) showed no comment indicating any dampers were disconnected or out of service. Reference: NFPA 101, 2000 Edition; 4.6.7* Modernization or Renovation. Any alteration or any installation of new equipment shall meet, as nearly as practicable, the requirements for new construction. Only the altered, renovated, or modernized portion of an existing building, system, or individual component shall be required to meet the provisions of this Code that are applicable to new construction. If the alteration, renovation, or modernization adversely impacts required life safety features, additional upgrading shall be required. Existing life safety features that do not meet the requirements for new buildings, but that exceed the requirements for existing buildings, shall not be further diminished. In no case shall the resulting life safety features be less than those required for existing buildings.	K 067		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073	1. Families and residents will be provided with education regarding live wreaths so they don't bring anymore highly flammable decorations into the facility unknowingly during Christmas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/20/2011

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
K 073	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure highly flammable decoration were not used in 1 of 6 smoke compartments. The findings were: Observation of resident room #301 on 12/19/11 at 3:41 PM showed a live pine bow wreath was attached to the exterior side of the corridor door. Further observation showed the pine needles were dry and brittle. At the time of the observation the maintenance director reported he was aware dead pine tree decorations were prohibited in healthcare facilities. Furthermore, he assumed the wreath in question was made from artificial bows.	K 073	Next year, we will remind them with a newsletter ahead of time. Completion Date: December 21, 2011 This will be monitored by environment of care walkthroughs, staff rounds, and reported monthly at Safety Committee meeting.	12-21-11
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure oxygen cylinders were	K 076	1. Oxygen is being restrained in the oxygen store room. 2. The electrical outlet has been deactivated and capped with an electrical plate cover on January 12, 2012. A motion sensor light will be installed in the ceiling in place of the light switch. The light switch will be capped off and the wires pull and re-routed to the motion sensor. Completion Date: February 5, 2012 These will be monitored through environment of care walkthroughs and reported out quarterly at Safety Committee.	2-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 076	Continued From page 12 restrained and failed to ensure electrical fixtures and outlets were properly installed in 1 of 6 smoke compartments. The findings were: 1. Observation of the oxygen storeroom on 12/19/11 at 3:12 PM showed the oxygen cylinder storage racks were full. Further observation showed three oxygen cylinders were sitting on the floor and not restrained. At the time of the observation the maintenance director reported he was aware all oxygen cylinders were required to be restrained. The director of nursing could not explain why the nursing staff had not noticed the unrestrained cylinders and restrained them during the daily use of the room. 2. Observation of the oxygen storeroom on 12/19/11 at 3:13 PM showed the electrical outlet behind one of the oxygen cylinder carts was installed 24 inches above the floor. Further observation showed the light switch was installed 48 inches above the floor. At the time of the observation the maintenance director was unaware all electrical fixtures, switches and outlets are required to be 60 inches (6 ft) above the floor. Reference: NFPA 101, 2000 Edition, 19.3.2.4, NFPA 99, 1999 Edition: 4-3.5.2.1 (b) 27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. 4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a) Nonflammable Gases (any Quantity; In-storage, Connected, or Both) 4. The electric installation in storage locations or	K 076	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2008 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
K 076	Continued From page 13 manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electrical wall fixtures, switches and receptacles shall be installed in fixed locations not less than 5 ft above the floor as a precaution against their physical damage.	K 076		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 2 of 6 smoke compartments. The findings were: Observation of the electrical system on 12/19/11 between 2 PM and 3:30 PM showed a washing machine in the laundry was plugged into a 3-way electrical adapter. The computer in the activities room and the television set in resident room #404 were plugged into two surge protectors in-line. At 2:03 PM the maintenance director could not explain why the aforementioned electrical adapter had not been noticed and removed during the quarterly inspections. Reference: NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition; 400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a	K 147	The three prong adaptor has been removed and a 4-gang receptacle outlet has been added by an electrician. Completion Date: January 12,2012 This will be monitored by the EVS Supervisor and reported quarterly to Safety Committee.	1-12-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/20/2011

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
K 147	Continued From page 14 structure (2) Where run through holes in walls ... (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	12/20/2011

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
K000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, New Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2007. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 28 certified Medicaid beds with a census of 28 residents.	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027	The latch on the smoke barrier door in the link had the latches fixed and the smoke barrier door near room 539 had metal smoke seal dragging that was removed. Both doors now latch properly. Completion Date: December 21,2011 This will be monitored and tested monthly with a preventative maintenance schedule. Any repairs will be made immediately. This will be reported quarterly to the Safety Committee.	12-21-11

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

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.

for Natalie Korell w/ Natalie Korell, MHA

DN 1/27/12

WY Dept of Health
JAN 23 2012
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	12/20/2011

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

1/27/12

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 3 smoke barrier double doors were smoke resistant. The findings were: Observation on 12/19/11 between 4 PM and 5 PM showed all smoke barrier doors were equipped with self-closing devices. Further observation showed one of the 600 corridor link double doors and one of the living room double doors (# 539) were not able to fully latch into the door frames with three attempts each. At 4:07 PM the maintenance director could not explain why the doors had not been noticed and repaired during the quarterly inspections.	K 027		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation, blue print review, and staff interview, the facility failed to ensure non-exit doors were properly designated in 2 of 4 smoke compartments. The findings were: Observation of the egress system on 12/19/11 at 4:22 PM showed the south courtyard double doors were posted with a sign that read "push	K 038	The signage has been removed from both living room areas and new signs, that read "Not an Exit" has been posted in both living room areas. Completion Date: January 5, 2012 This will be monitored by environment of care walk through and reported quarterly at Safety Committee.	1-5-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	12/20/2011

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
K 038	Continued From page 2 until alarm sounds, door can be opened in 15 seconds". However, after applying pressure for 15 seconds, the magnetic locks did not release the doors. At the time of the observation the maintenance director reported the delayed egress locks had been modified so they did not release with pressure, only with the key pad and loss of power. He also reported these doors were not exit doors and the exit sign in the area was intended for the smoke barrier doors in the area. When asked why the doors were not signed with "No Exit" he reported he was unaware of that requirement. Review of the blue prints at 4:30 PM confirmed the doors were not required exit doors, which was also confirmed by the administrator at that same time. She could not explain why the delayed egress sign was still posted and why a "No Exit" sign was not posted. At 5:03 PM observation of the north courtyard double doors showed the same configuration. Reference: NFPA 101, 2000 Edition, 19.2.2.2.4; 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved,	K 038	This page left blank intentionally	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	12/20/2011

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
K 038	Continued From page 3 supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d)* On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101, 2000 Edition, 19.2.10.1; 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038	This page left blank intentionally	