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

PRINTED: 05/04/2010
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 01 - MAIN BUILDING 01 B. WING _____	04/22/2010

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 the Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise privided in the 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. The facility was a fully sprinklered single story building of Type V (III) construction built in 1998 with a connecting Alzheimer Unit built in 2009. The building was equipped with a supervised automatic wet sprinkler system with a dry branch in the attic and an addressible fire alarm system.	K 000	RECEIVED Wyoming Dept of Health JUN 08 20 Office of Healthcare Licensing and Surveys	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the smoke barrier was maintained as a continuous membrane in 1 of 7 smoke compartments. The findings were: Observation on 4/21/10 between 11 AM and 2 PM revealed the follow concerns: 1. A half inch hole was noted in the wall of the medical record room in the 400 hall. Interview with the maintenance manager at the time revealed the hole was probably from an electrical cable and needed to be filled. 2. In the bathroom in the 400 hall, a metal frame surrounding an 8-inch ceiling light was dislodged,	K 012	The half inch hole was patched with spackling compound in the 400 hall nurses office by Plant Operation Techs on the 23rd of April. These similar problems will be monitored by our safety walk through and through maintenance checks quarterly and be reported to safety committee. The metal frame surrounding an eight inch ceiling light in the 400 hall shower that had a gap in between the frame and the cut out from the light was fixed by making a bigger frame for the frame that covered the hole of the cut out for the light. This was fixed by Plant Operation techs on the 26th of April and these similar problems will be monitored by our safety walk through and through maintenance checks quarterly and be reported to safety committee.	Overall total tag element completed by: 6/20/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mertalee Ford | TITLE: Administrator | (X6) DATE: 5/14/10

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.

State Survey Agency
Wyoming Dept of Health

632-4038 Revised/approved changes on pages #2 and #4 after TC to DON on 6/2/10 @ 2:48pm — SL

Office of Healthcare
Licensing and Surveys

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K 012	Continued From page 1 revealing a gap between the frame and the ceiling. Interview with the maintenance manager at that time confirmed the gap needed to be covered.	K 012		
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. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 1 corridor door was resistant to the passage of smoke in 1 of 7 smoke compartments. The findings were: Observation on 4/21/10 between 11 AM and 2 PM revealed the corridor door to resident room #413 did not completely close in its frame. A power cord was observed attached to an electric	K 018	The cord that was plugged into the wheelchair impeding the door from closing was removed, The maintenance staff and Goshen Care Center Supervisor talked to the resident that the wheelchair belonged to. On the 26th of April the resident's gave his permission to have the wheelchair be moved to a storage room where it could be plugged in and still be able for the resident to have access. The impedance of corridor doors will be monitored by nursing staff and Plant Operation personnel weekly and reported to safety committee.	Overall total tag element completed by: 6/20/10

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K 018	Continued From page 2 wheelchair parked in the corridor. The power cord was plugged into an electrical outlet inside the resident's room. As a result, the corridor door could not be closed. Interview with the maintenance manager at the time of the observation confirmed the electric power cord prevented the door from being closed.	K 018		
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 7 smoke barrier doors was resistant to the passage of smoke. The findings were: Observation on 4/21/10 at 10 AM revealed the smoke barrier door in the 300 hallway did not completely close during a fire drill. The administrator and maintenance manager both confirmed the observation. The maintenance manager stated the door probably didn't close because of negative air pressure and needed to be adjusted.	K 027	On the 22st of April the 300 hall smoke barrier doors where adjusted by the door closers by Plant Operations techs. These will be monitored by Plant Operation Techs and nursing staff weekly and reported to safety committee.	Overall total tag element completed by: 6/20/10
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 047	Tag K 047 begins on Page 4	

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K 047	Continued From page 3 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 4 emergency exits were properly identified in the special care unit (SCU). The findings were: Observation on 4/21/10 between 11 AM and 2 PM revealed one of four SCU emergency exits was not identified by an emergency exit sign. In addition, a second emergency exit (in the dining room) was not properly identified by a corridor emergency exit sign. The sign was not correctly configured. The directional arrow on the sign was not punched out pointing to the exit. Interview with the maintenance manager at the time of the observation confirmed the above two observations.	K 047	On the 26th April the sign that was not marked by a directional arrow was fixed by Plant Operations. The second exit sign ~~that was~~ cited for not being ~~correctly configured~~, this was mismarked on the evacuation plan and has been redone. The front door of the 300 hall is not designed as a fire exit this will be fixed by 17th of May by Safety Officer and reported to safety committee. Directing traffic through the dining room to the emergency exit	Overall total tag element completed by: 6/20/10
K 056 SS=D	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	K 056	On the 7th of May an escutcheon was ordered from Phoenix Fire and will be installed by Plant Operation Techs the day of the arrival estimated arrival is 19th of May. This will be monitored by Plant Operation Techs quarterly and reported to safety committee.	Overall total tag element completed by: 6/20/10

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K 056	Continued From page 4 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 1 of 6 sprinkler heads on the facility exterior overhang was installed as required. The findings were: Observation on 4/21/10 between 11 AM and 2 PM revealed one of the sprinkler heads on the exterior overhang was missing an escutcheon. As a result, a one inch gap existed between the sprinkler head and the overhang surface. The maintenance manager stated at that time, "The wind must have knocked it off."	K 056		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to inspect 1 of 23 portable fire extinguishers during 1 of the previous 12 months in accordance with NFPA 10 Section 4-4.3 & Table 5-2. The findings were: Review of facility's maintenance records revealed a "K" type portable fire extinguisher located in the special care unit kitchen was not inspected during the month of March 2010. Interview with the	K 064	On the 21st of April the class K fire extinguisher was checked and marked by Plant Operation techs. This will be monitored by Plant Operation techs every month in accordance with fire extinguisher policy and reported to safety committee.	Overall total tag element completed by: 6/20/10

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K 064	Continued From page 5 maintenance manager on 4/21/10 at 1:48 PM confirmed the extinguisher was not inspected in March.	K 064		
K 147 SS=D	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 electrical wiring was in compliance with the National Electric Code in 1 of 7 smoke compartments. The findings were: Observation on 4/21/10 at 12:48 PM revealed one wall-mounted electrical outlet was not ground fault circuit interrupter (GFCI) protected. The outlet was located over the counter within six feet of the sink in the clean linen room in the 300 hall. Interview with the administrator at the time of the observation confirmed the observation.	K 147	The GFIC in the 300 hall clean linen room will be installed by Pittman Electric on the 14th of May. This will be monitored by Plant Operation Techs quarterly and reported to safety committee.	Overall total tag element completed by: 6/20/10