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WY Dept of Health
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Healthcare Licensing and Surveys

PRINTED: 02/12/2014
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	R 01/29/2014

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 DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse CNA: Certified Nursing Assistant ADL: Activities of Daily Living LPN: Licensed Practical Nurse URI: Upper Respiratory Infection	{F 000}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to ensure interventions to decrease the risk of falling were implemented for 3 of 6 sample residents (#4, #50, #59) identified as having falls. The findings were: 1. Review of the medical record showed resident #50 was admitted to the facility on 9/10/13 with diagnoses including dementia and confusion. The medical record further revealed the resident had sustained a fall on 7/24/13 which resulted in a right hip fracture which required surgical repair with hardware placement. Review of the quarterly MDS assessment dated 12/30/13 showed the resident was severely cognitively impaired, had	{F 323}	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This will be accomplished by: A) Providing supervisors on the floor to augment current staffing levels to assist with supervision, care delivery and overall operations. a. Maintain staffing schedule to provide appropriate care delivery for all residents. b. Maintain hourly rounding procedure to ensure proper care delivery for all residents. c. Provide continuing education/training on resident safety and supervision. d. Resident's #50 and #59 sensor alarms were immediately placed in their chairs in accordance with the care plan. e. DON arranged resident #4 PT evaluation on 02/04/14.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle D. DeMuth, NHA #108 | TITLE: Interim Administrator | (X6) DATE: 2/21/14

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.

Accepted by Kalee Treon on 2/27/14

Spoke w/ Kathleen Keane on 3/27/14 DC - 3/3/14

2/27/14

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(F 323)	Continued From page 1 decreased range of motion (ROM) in bilateral upper and lower extremities and required extensive assistance from staff for ADL's. Review of the care plan updated 1/23/14 showed the resident was at high risk for falling related to mental status, impaired mobility and recent history of falls. Interventions included placing a sensor alarm in bed; placing a pull tab alarm in the bed and chair, and having a low bed. Review of the resident's medical record further revealed the resident sustained an unwitnessed fall from a reclining chair on 1/23/14. Post fall interventions included staff, "instructed resident on safe transfer techniques [and] use of call light". The following concerns were identified: a. Observation on 1/27/14 at 1:45 PM showed the resident was asleep in a reclining chair near the nursing desk on the 300 hall. There were no alarms in place. b. Observation on 1/28/14 at 5 PM with RN #1 showed the resident was seated in a reclining chair near the nursing desk on the 300 hall and there were no alarms in place. The resident had slid down in the chair and had his/her legs hanging over the foot rest of the recliner. Interview with RN #1 at the time of the observation revealed s/he was unsure whether the resident utilized any alarms. Interview with CNA #1 at the time of the observation revealed s/he was also unsure whether the resident utilized any alarms. c. Observation on 1/29/14 at 9:30 AM revealed the resident was asleep in a regular bed in his/her room. Interview with CNA #2 at the time of the observation confirmed the bed could not be lowered to a lower position and was not a low bed. The height of the bed from the top of the mattress to the floor was 30.5 inches. Interview with RN #1 at the time of the observation also	(F 323)	f. Resident #4 also has appropriate sensory alarms in place in accordance with the care plan. B) The care plans of the identified residents were reviewed for needed changes and all new and existing interventions are implemented. a. All care plans are available to CNAs on the floor in the care plan book established by the MDS Coordinator. C) DON or designee provided immediate education to facility nursing staff and will provide on-going education as needed on the following topics: a. Falls prevention and proper resident supervision. b. Urgency towards fall alarms c. The Falling Stars Program d. Documented Hourly Rounds e. Safety Interventions, monitoring and compliance f. Post Fall Huddles g. Communication of updated resident interventions via pre shift report The facility DON or designee will conduct an audit on all falls to ensure that facility fall prevention systems are in place and that appropriate assessments and/or interventions have been implemented. The facility DON or designee will also conduct observations of staff supervision and compliance towards resident fall prevention interventions. Any staff	

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(F 323)	Continued From page 2 confirmed the resident did not have a low bed but was supposed to according to the care plan. In addition, the RN verified the resident was supposed to have a sensor alarm in his/her bed and a pull tab alarm while in the bed or chair. The interview further revealed there was no process to ensure preventative fall interventions were in place per the resident's individualized care plans. 2. Review of the medical record showed resident #59 was most recently re-admitted to the facility on 8/8/13 with diagnoses that included Alzheimer's disease, diabetes mellitus, obesity and back pain. Review of the 11/20/13 significant change MDS assessment showed the resident required extensive assistance of 2 staff for bed mobility, transfers and ambulation. Further review of this MDS assessment showed the resident had unsteady balance when moving from a seated to standing position. Finally, review of the MDS assessment showed the resident had bilateral ROM impairment in both upper and lower extremities. Review of the resident's care plan showed an intervention, dated 12/26/13 "Sensor alarm; make sure plugged in. "Observation of the resident on 1/29/14 at 10:45 AM revealed the resident was seated in his/her wheelchair in the dining room. No sensor alarm was in place. When asked at the time of the observation if the resident was supposed to have a sensor alarm, CNA #9 stated, "Alarm? That I don't know. I think so." Further review of the medical record showed the resident had fallen 5 times in the period from 12/26/13 through 1/29/14. 3. Review of the medical record showed resident #4 was admitted to the facility on 7/31/13 with diagnoses that included Alzheimer's disease. Review of the 11/12/13 quarterly MDS	(F 323)	member found not to be in compliance with the fall prevention program will receive immediate education. D) The 500 hall will be configured so that direct line of sight of residents, by staff, can be increased to reduce fall risk. Two way radios will be in place to increase staff communication of location of residents. E) The results of the fall audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. The audits will continue until such time that compliance is sustained at ≥90% compliant for a period of 120 days or 4 months. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	3/03/14

JB 2/21/14

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(F 323)	Continued From page 3 assessment showed the resident had limitation of ROM in both upper and both lower extremities. Additionally, the resident required limited assistance with bed mobility and ambulation. Finally, review of this MDS assessment showed the resident required supervision when moving from a seated to standing position. Review of the 12/20/13 nursing notes timed at 10:03 PM showed the resident "had difficulty standing after resting in recliner after supper for short time, assist of 2 staff to transfer to wheelchair..." Review of the 12/22/13 nursing notes timed at 6 PM showed the resident experienced a change from baseline "...greater confusion/more pronounced decrease in functioning." Review of the 12/27/13 nursing notes timed at 3:52 PM showed "Increased difficulty with short term memory, gait and balance more unsteady.." review of the 1/7/14 nursing notes timed at 5:53 PM showed the resident was "more unsteady on feet..." On 1/12/14 the nursing note timed at 6:30 PM indicated the resident was "not standing very well today." Finally, review of the 1/15/14 nursing notes timed at 6:08 PM showed the resident was described as "does not stand very well in transfers..." The following concerns were identified with fall prevention and the resident's decline in condition since the 11/12/13 quarterly MDS assessment was performed: a. A late entry nursing note timed for 1/5/14 at 6:35 PM showed the resident sustained a witnessed fall and,"slid" out of his/her wheelchair while attempting to,"sit down." The same note further showed a "..referral sent to PT..." Review of the medical record showed no evidence the resident was evaluated by the PT after the fall as recommended. b. Interview with the DON on 1/29/14 at 11:40 AM verified physical therapy had not received a	(F 323)	This page left blank intentionally	

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{F 323}	Continued From page 4 physician's order to evaluate the resident; nursing staff did not follow up on the physical therapy referral after the fall on 1/5/14. c. Observation on 1/27/14 at 2:15 PM revealed the resident was propelling him/herself in a standard wheelchair. The resident was observed to propel him/herself over to a low wall and pull him/herself up out of the wheelchair attempting to stand before sitting back down in the wheelchair. There were no staff present during the observation to provide supervision.	{F 323}		
{F 441} SS=K	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	{F 441}	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program. The facility must establish an Infection Control Program under which it (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens. Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This	

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{F 441}	Continued From page 6 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and procedures and infection control documentation, the facility failed to effectively implement measures to prevent the spread of a known respiratory infection occurring within the facility. This failure resulted in an immediate jeopardy situation. The census was 88. The findings were: On 1/21/14 at 12:45 PM, surveyors were instructed by the infection preventionist (IP) to wear a mask prior to touring or entering the 200 hall because the entire hall was on isolation precautions. The IP further instructed surveyors to dispose of the mask and perform hand hygiene before leaving the 200 hall. Observation of signage posted on resident rooms on 1/21/14 at 12:40 PM revealed the facility had residents who were on droplet isolation precautions for signs and symptoms of influenza and respiratory infection. Review of the infection control documentation showed as of 1/19/14 residents #57 and #8 tested positive for influenza rapid diagnostic testing indicating they were infected	{F 441}	will be accomplished by: A) Nursing will assess and monitor each resident that exhibits: a. 2 degree temperature change from the resident's baseline. b. Productive cough. c. Nasal drainage. B) Each resident that exhibits the signs and symptoms indicated in "a" above will be placed on the Hospitalist list for examination by physician within 4 hours of notification. The physician will determine whether further testing is warranted and the course of treatment. C) The Hall nurse will assess all residents daily as described in "a" above until seven days after the last positive influenza resident has been identified. Any necessary testing will be left to the resident's primary care physician's discretion. D) In addition, special focus will be provided to residents identified as "high risk" in the Emergency Influenza Plan. Examples of high risk residents are those that have not received the flu vaccine, those with chronic health conditions such as COPD, and those with a compromised immune system. E) Facility will follow policies for	

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(F 441)	Continued From page 6 with influenza type A. In addition, other residents including all residents on the 200 hall (#1, #2, #3, #5, #7, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #25, #26, #27, #76) and 9 residents on the 300 hall (#30, #31, #32, #33, #35, #41, #42, #52, #53) were placed on droplet precautions for cough and elevated temperatures with symptom onset dates of 1/18/14 and 1/19/14. On the 400 hall, 2 residents were identified, #57 who was known positive for influenza A, and the roommate (#58) with a 1/19/14 onset date of influenza-like symptoms. Both were on droplet precautions and exhibited elevated temperatures and coughs. As of 1/22/14, there were no residents on the secure unit identified with signs and symptoms of respiratory infection. The following concerns with implementing infection control practices were identified: a. Observation of the 200 hall on 1/21/14 at 3:55 PM showed three CNA's and one nurse were working. The area was closed off to the rest of the facility and carts were located outside the doors to the hall which were stocked with disposable masks, gowns, and gloves. The cart also included hand sanitizing gel. Observation at 4 PM showed CNA #5 put on a mask that was already around her neck to go in and assist resident #8 (known positive for influenza). The aide used hand sanitizer when entering the room, but did not wear any gloves. While in the room the aide was observed touching the resident's shoulders, and handling the resident's wheelchair while helping him/her into the bathroom. The aide failed to wear any personal protective equipment (PPE) other than the mask while assisting the resident. The aide then exited the room, used hand sanitizer and failed to dispose of the mask. The aide lowered the mask down below her nose	(F 441)	Droplet Precautions and Outbreak Investigation and Control for those residents that qualify. F) Facility follows all recommendations from the CDC and State of Wyoming's epidemiologist concerning infection prevention. These recommendations were used to create policy and protocol to manage influenza by utilizing the Influenza Outbreak Management Policy and Procedure. G) DON or designee provided immediate education to facility nursing staff and will provide on-going education as needed on the following topics: a. Infection Control practices. H) The facility DON or designee will conduct an audit on all residents who are ill, to ensure that facility infection control systems are in place and that appropriate assessments and/or interventions have been implemented. The facility DON or designee will also conduct audits of staff supervision and compliance towards resident infection control interventions. Any staff member found not to be in compliance with infection control practices will receive immediate education. I) The results of the infection control	

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(F 441)	Continued From page 7 and mouth and continued to work in the main area around other residents. Interview with the other two CNA's working on the hall (CNA #6 and #7) at 4:30 PM revealed they wore their same masks without changing them between resident contact. They also did not wear the masks around their nose and mouth unless they were in direct contact with the residents. Interview with LPN #1 at 4:20 PM revealed the area was put on isolation restriction starting the evening of 1/19/14. She also revealed there was not an education or training session provided to staff related to this instance of hall isolation taking place. The nurse stated staff had an education in December 2013 related to isolation precautions and use of PPE. b. Observation on 1/21/14 at 4:40 PM showed resident #40 was seated in his/her wheelchair in the 300 hall. The resident was flushed, had red, watery eyes, a productive cough and audible wheezing. The resident stated, "I feel bad, my throat is sore and I [have] been coughing up stuff." After the interview nursing staff were made aware of the resident's complaints by the surveyor. Observation on 1/21/14 at 6:05 PM showed the resident was seated in the main dining room with other residents, staff, and visitors. The resident was productively coughing into a napkin and unable to eat. RN #3 offered assistance with eating, however, did not address the resident's productive cough. Interview with the DON at the time of the observation revealed the resident was eating in the main dining room because s/he did not have a fever. However, review of the resident assessment results dated 1/22/14 at 4 PM showed the resident was wheezing, had a temperature of 102.6 degrees Fahrenheit (F), was seen by the physician, placed on droplet precautions, and received an order for Tamiflu (used to treat influenza) 75 mg	(F 441)	audits will be tabulated and reported at the facility's monthly Performance Improvement Committee. The audits will continue until such time that compliance is sustained at ≥90% compliant for a period of 120 days or 4 months. Appropriate follow up actions will be initiated by the Performance Improvement Committee.	3/03/14

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{F 441}	Continued From page 8 (milligrams) daily. c. Observation on 1/21/14 at 3:45 PM showed there were 6 resident rooms on the 300 hall and 2 resident rooms on the 400 hall that had droplet precaution signs posted on the door. Observation from 3:45 PM until 5:10 PM showed CNA's #3 and #4 were wearing the same disposable masks into rooms posted with droplet precautions and rooms that were not posted. Observation also showed CNA #4 was wearing the disposable mask below her nose. Interview at that time with CNA #4 revealed the CNA's were told they only had to wear a mask if they had not had the flu shot or if they chose. The interview further revealed the CNA wore the same mask for the entire shift. Observation at 4:40 PM revealed CNA #8 exited the room of resident #57 (who had tested positive for influenza) and then entered another resident's room across the hall wearing the same disposable mask. d. During the observation on 1/21/14 at 3:45 PM, CNA #3 exited a droplet precaution room with bare hands carrying soiled linens held against her clothing and deposited the linens into a cart in the hall. Observation of the soiled utility room at 5 PM showed there were unbagged soiled linens on the floor and bagged trash on the floor not contained in a trash receptacle. CNA #4 was observed entering the soiled utility room with bagged trash. The CNA picked up the soiled linens and the bagged trash off the floor and placed them into receptacles using bare hands. e. Observation of RN #2 at 5:10 PM revealed the RN was wearing a personal cloth face mask. Interview with the RN at the time revealed she did not take the influenza immunization and had to wear a mask during flu season because that was the facility's policy. The RN indicated the mask was her own personal mask.	{F 441}	This page left blank intentionally	

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(F 441)	Continued From page 9 f. Interview with the IP on 1/22/14 at 9:05 AM verified masks were disposable and should be discarded after each resident contact. Interview further revealed she expected staff to follow the facility's policy and use the disposable masks provided by the facility and not personal masks. In addition, she verified a resident with an active cough should not have been taken to the dining room. Related to staff education, the IP verified she had not provided any specific education or training to staff related to the outbreak occurring in the facility. g. Interview with the DON on 1/21/14 at 5:15 PM revealed a decision was made to discontinue the droplet precautions for 24 residents on the 200 hall with the exception of resident #8. Droplet precautions were discontinued even though additional resident specimens that had been collected and sent to the State Epidemiology Lab to verify influenza were pending. The DON stated the reason for discontinuing the isolation precautions was because none of the residents had a temperature that day of over 100 degrees F. Observation on 1/21/14 at 5:55 PM verified the doors were open and the residents who were previously isolated with the exception of resident #8 were now co-mingling with other residents in the main dining room. At this time it was noted the droplet precaution signs were removed from the area, and there was no housekeeping/cleaning personnel working in the area. Interview on 1/22/14 at 9:05 AM with the DON, the IP and the administrator revealed cleaning of the 200 hall area and rooms was started that morning (1/22/14). The interview revealed according to policy and procedure, the cleaning should have been implemented the night before when the precautions were discontinued. h. Interview with the IP on 1/22/14 at 3:45 PM	(F 441)	This page left blank intentionally	

2/27/14

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

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 _____	R 01/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(F 441)	Continued From page 10 revealed 10 resident specimens (all from the 200 hall) were sent to the State Epidemiology Lab for further testing and the results were pending. Review of documented test results provided on 1/23/14 showed, 2 specimens were unable to be tested, and the other 8 specimens from residents (#1, #2, #8, #17, #19, #20, #22, #76) were shown to be positive for Influenza A infections consisting of a subtype A 3 strain. I: Review of an employee illness log showed 11 employees had one or more of the following symptoms: "chills, fever, uri [upper respiratory infection], d [diarrhea], n [nausea], vomiting." The dates of these employee absences due to illness ranged from 1/6/14 to 1/23/14. Interview with the IP on 1/22/14 at 9:05 AM revealed tracking of employee illness was done in "retrospect", she also stated the tracking was incomplete making it difficult to ensure staff did not return to work while potentially contagious. J. Review of policies and procedures failed to show procedures were developed related to influenza infection in a vulnerable, elderly long term care population. In addition, the facility policy and procedures were not implemented for adhering to proper procedures with droplet precautions or with tracking employee illness information. Review of an e-mail dated 1/16/14 at 7:58 AM to all employees from the corporate VP/CMO (chief medical officer) showed it was for "Implementation of Visitor Restrictions and Return to Work procedures." Review of the procedures showed they were effective 1/20/14, and "Any employee with respiratory illness may not return to work until all of the following criteria are met: * without fever for at least 24 hours without the use of fever reducing medications and away from work for (7) calendar days after onset	(F 441)	This page left blank intentionally	

SB 2/28/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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(F 441)	Continued From page 11 of symptoms. * If employee can provide written proof from their physician to Occupational Health of a confirmed non-contagious alternate diagnosis (i.e. sinus infection), they may be released to work prior to the seven-day period. * Cleared through Occupational Health * If employee has residual cough when returned to work in patient care facilities he/she will be required to mask while at work until symptoms have resolved." On 1/22/14 at 11:50 AM the administrator was notified of an immediate jeopardy situation in the area of infection control. The facility's action plan included the immediate changes; a. The facility will complete a nursing assessment on 100% of residents to determine any signs and symptoms of URI. b. Each resident identified with signs and symptoms of URI will be seen by a physician within 4 hours. The physician will determine further testing and course of treatment. c. The facility will immediately implement the policies and procedures related to Droplet Precautions and Outbreak Investigation and Control. d. The facility will follow recommendations from the Centers for Disease Control and Prevention and the State of Wyoming epidemiologist concerning infection prevention. These recommendations will also be used for developing a policy and procedure to manage influenza outbreaks in the future. e. The leadership team will conduct education and training to 100% of staff on droplet precautions and outbreak investigation and control at the beginning of each shift. f. The facility will inform visitors of the	(F 441)	This page left blank intentionally	

SB 2/27/14

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{F 441}	Continued From page 12 outbreak of URI and provide guidance and appropriate PPE with instructions for use. g. The facility will implement the personnel health policy requiring tracking of employees who are ill and enforcing the specified return to work criteria. The action plan was accepted on 1/23/14 at 10:10 AM, and based on implementation of the plan, the immediate jeopardy was abated on 1/23/14 at 2 PM. However, deficient practice remained at a scope and severity of H (actual harm that is not immediate jeopardy). Review of updated information provided on 1/23/14 showed 6 additional residents were identified through the action plan as having signs and symptoms of possible URI. Those identified included 4 residents on the Secure unit (#69, #77, #80, #82) and residents #33 and #40. These residents were put on isolation precautions and were seen by a physician.	{F 441}	This page left blank intentionally	