Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0010	A. BUILDING: _____ B. WING _____	06/19/2014

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) COMPLETE DATE
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Nursing Care Facilities, Chapter 11, effective 06/26/2000 Rules and Regulations for Licensure of Nursing Care Facilities, Chapter 19, effective 06/26/2000 . The following common abbreviations are used throughout this document: ADL- Activities of Daily Living BIMS- Brief Interview for Mental Status CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set Assessment Less commonly used abbreviations will be annotated in each deficiency.	S 000		
S2967	Ch 11 Sec 9 (c)(iii) Nursing Services The facility shall have sufficient nursing staff to meet the needs of the residents. (c) Restorative Nursing Care. There shall be an active program of restorative nursing care directed towards assisting each resident to achieve and maintain his/her highest level of self care and independence. This program shall include: (iii) Making every effort to keep residents active and out of bed for reasonable periods of time, except when contraindicated by physician's orders, and encouraging residents to achieve	S2967	S2967 The facility will ensure to have sufficient nursing staff to meet the needs of the resident & provide restorative nursing care. This will be accomplished by: A. 1) Resident #5 was referred for PT consult on 6/19/14. PT evaluated and recommended continuation of restorative care. Restorative care plan in place to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen A. Keane | TITLE: NHA | (X6) DATE: 7-11-14

STATE FORM 6899 4JYK11 If continuation sheet 1 of 4

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WY Dept of Health
JUL 14 2014
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POC approved with administrator on 7-24-14 with Janelle Conlin.