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

PRINTED: 12/11/2014
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 _____	12/03/2014

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

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities 42 CFR 483.70 (a) except as otherwise provided 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 (NFPA). The facility was a fully sprinklered, single-story building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system that communicates with the Alzheimer building (SCU). The facility had a capacity of 103 certified Medicaid beds with a census of 77.	K 000	This plan of correction does not constitute admission and/or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared as required by regulation. To remain in compliance with all Federal and State regulations, the center has taken or will take the actions set forth in the following plan of correction. The plan of correction constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 029 SS=D	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 interview, the facility failed to provide doors to hazardous locations that were self-closing in 1 of 6 smoke compartments. The findings were:	K 029	**K029 : NFPA 101 Life Safety Code Standard** **Corrective Actions:** The Facility Maintenance Director installed a self-closing/automatic closing device on the doors of the linen and EVS storage areas between the 300 and 400 wings. **Others Potentially Affected:** All residents on the 300 and 400 wings have the potential to be affected by this practice. **Systemic Changes:** • The Facility Maintenance Department will be educated on the NFPA regulation that rooms storing hazardous materials must have self-closing doors.	1/18/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

NHA — 1-9-15

Director Of Nursing — 1-7-15

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.

PLAN OF CORRECTION (POC) ACCEPTABLE WITH MIKE SPEIDEL (ADMIN) ON 01/09/15

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K 029	Continued From page 1 Observation of Linen Storage between the 300 & 400 wings at 1:56 PM, EVS Storage at 2:00 PM, and Storage off of the main lobby at 4:45 PM all on 12/03/14 revealed the lack of self-closing or automatic-closing devices on these doors storing hazardous content. Interview of the Maintenance Director confirmed the observed conditions. REFERENCE 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (7) Rooms or spaces larger than 50 ft2 (4.6 m 2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction.	K 029	• An audit of all facility doors leading into rooms that store hazardous materials will be completed by the Facility Maintenance Director. Any issues regarding the absence of door closers will be corrected. **Monitoring:** The Facility Maintenance Director or designee will audit the doors leading into hazardous material storage rooms weekly x 4 weeks, monthly x 3 months, and random thereafter. **QA:** The Facility Maintenance Director will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
K 043 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 This STANDARD is not met as evidenced by:	K 043		

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K 043	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide doors in the mean of egress that were readily accessible at all times in 2 of 3 smoke compartments in the SCU. The findings were: 1. Observation at 10:40 AM on 12/03/14 revealed the required means of egress from the Dining Room to the exterior was secured with an access-controlled system that did not unlock the door per an approaching occupant and did not unlock the door per a manual release. Interview of the Maintenance Director confirmed the observed condition. The Maintenance Director explained that the overhead magnetic lock would release upon the input of the correct code into the adjacent keypad or by the activation of the fire alarm and/or fire suppression system. 2. Observation at 11:28 AM on 12/03/14 revealed the required means of egress from the SCU to the adjacent nursing care facility was secured with an access-controlled system that did not unlock the door per an approaching occupant and did not unlock the door per a manual release. Interview of the Maintenance Director confirmed the observed condition. The Maintenance Director explained that the overhead magnetic lock would release upon the input of the correct code into the adjacent keypad or by the activation of the fire alarm and/or fire suppression system. REFERENCES 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 043	**K043: NFPA 101 Life Safety Code Standard** **Corrective Actions:** Facility Maintenance Director contacted a qualified vendor to modify the two doors on the secured unit to release after 30 seconds of pressure is applied directly on the door. The vendor will make this modification and proper signage will be hung per NFPA guidelines. **Others Potentially Affected:** Residents residing on the Secured Unit have the potential to be affected by this practice. **Systemic Changes:** • The Facility Maintenance Department will be educated on the NFPA requirement regarding secured egress doors • An audit of all locked doors providing a means of egress for the Secured Unit will be conducted by the Facility Maintenance Director or Designee. All findings in result of this audit will be corrected by Facility Maintenance Director/Designee or a qualified vendor.	1/16/2015

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K 043	Continued From page 3 Exception No.1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No.2: *Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No.3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6 Special Locking Arrangements. 7.2.1.6.2 Access-Controlled Egress Doors. Where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (a) A sensor shall be provided on the egress side and arranged to detect an occupant approaching the doors, and the doors shall be arranged to unlock in the direction of egress upon detection of an approaching occupant or loss of power to the sensor. (b) Loss of power to the part of the access control system that locks the doors shall automatically unlock the doors in the direction of egress. (c) The doors shall be arranged to unlock in the direction of egress from a manual release device located 40 in. to 48 in. (102 cm to 122 cm) vertically above the floor and within 5 ft (1.5 m) of the secured doors. The manual release device shall be readily accessible and clearly identified	K 043	**Monitoring:** The Facility Maintenance Director or designee will audit all of the egress doors on the Secured Unit weekly x 4 weeks, monthly x 3 months, and random thereafter. **QA:** The Facility Maintenance Director will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful	

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K 043	Continued From page 4 by a sign that reads as follows: PUSH TO EXIT When operated, the manual release device shall result in direct interruption of power to the lock independent of the access control system electronics and the doors shall remain unlocked for not less than 30 seconds. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. (e) Activation of the building automatic sprinkler or fire detection system, if provided, shall automatically unlock the doors in the direction of egress and the doors shall remain unlocked until the fire-protective signaling system has been manually reset.	K 043	**K052: NFPA Life Safety Code Standard** 1/18/2015 **Corrective Actions:** Facility Maintenance Director contacted facility fire system vendor and received all available documentation on fire alarm testing and preventative maintenance. Appointments were also scheduled for vendor to conduct required testing and maintenance within the next sixty days. **Others Potentially affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • Facility Maintenance Department will be educated on NFPA requirements regarding fire alarm testing and maintenance. • An audit of all documentation related to facility fire alarm testing will be conducted by the Facility Administrator or designee to identify any further requirements needed.	
K 052 SS=E	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 This STANDARD is not met as evidenced by: Based on document review, the facility failed to test and maintain the fire alarm system in	K 052		

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K 052	Continued From page 5 accordance with NFPA 70 National Electrical Code and NFPA 72 National Fire Alarm Code and failed to keep records readily available. The findings were: Observation of the fire alarm documentation at 3:50 PM on 12/03/14 revealed that documentation was not available for the following fire alarm testing and maintenance requirements: 1. Monthly Activation (NFPA 72, Table 7-3.2, 23) for 8/2014 and 9/2014. 2. Annual - Annunciator Panel (NFPA 72, Table 7-3.2, 14) for 2014. 3. Semi-annual Battery Load Voltage (NFPA 72 Table 7-3.2 6, c, 3) for 2014 4. Annual Manual Fire Alarm Boxes (NFPA 72 Table 7-3.2, 15) for 2014 5. Annual Smoke Detector - in place, smoke entry (NFPA 72 Table 7-3.2, 15) for 2014 6. Bi-annual Smoke Detector sensitivity (NFPA 72 Table 7-3.2, 15). 7. Quarterly Waterflow Alarm Devices (NFPA 25, 9-2.7 & NFPA 72, 2-6.2) for 4th quarter of 2013. 8. Quarterly Supervisory Signal Devices (NFPA 72, 7-3.2) for 2nd, 3rd, and 4th quarters of 2014.	K 052	**Monitoring:** An audit of all documentation validating the proper fire alarm testing and maintenance was completed by a qualified vendor will be conducted by the Facility Administrator or Designee weekly x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Administrator will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful	
K 062 SS=D	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, 8.7.5 This STANDARD is not met as evidenced by: Based on document review, the facility failed to	K 062	**K062: NFPA Life Safety Code Standard** **Corrective Actions:** Facility Maintenance Director contacted facility fire system vendor and received all available documentation on the testing and maintenance of the facility sprinkler system. Appointments were also scheduled for vendor to conduct required testing and maintenance within the next sixty days. **Others Potentially affected:** All residents have the potential to be affected by this practice.	1/10/2015

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K 062	Continued From page 6 test and maintain the automatic sprinkler system in accordance with NFPA 13 and NFPA 25 and failed to keep records readily available. The findings were: Observation of the automatic sprinkler system documentation at 4:06 PM on 12/03/14 revealed that documentation was not available for the following fire sprinkler testing and maintenance requirements: 1. Quarterly Main Drain Test (NFPA 25, 9-2.6) for 4th quarter of 2013. 2. Dry System, Quarterly Priming Water (NFPA 25, 9-4.4.2.1) for 4th quarter of 2013. 3. Dry System, Low Air Alarm (NFPA 25, 9-4.4.2.6) for 4th quarter of 2013. 4. Dry System, Quick-opening devices (NFPA 25, 9-4.4.2.4) for 4th quarter of 2013.	K 062	**Systemic Changes:** • Facility Maintenance Department will be educated on NFPA requirements regarding facility sprinkler testing and maintenance. • An audit of all documentation related to facility sprinkler testing and maintenance will be conducted by the Facility Administrator or designee to identify any further requirements needed. **Monitoring:** An audit of all documentation validating the proper sprinkler testing and maintenance was completed by a qualified vendor will be conducted by the Facility Administrator or Designee weekly x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Administrator will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful	
K 073 SS=D	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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to restrict the use of combustible decorations in such limited quantities to limit the development or spread of fire. The findings were: Observation on 12/03/14 starting at 10:01 AM and throughout the survey revealed combustible decorations including the following: wreaths on resident room doors to the corridor, a Christmas tree in the 400 wing, tinsel roping at corridor crossings, and hanging ornaments in the dining	K 073		

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K 073	Continued From page 7 rooms. Interview of the Maintenance Director confirmed the observed condition. REFERENCE 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.	K 073	**K073: NFPA 101 life Safety Code Standard** **Corrective Actions:** The Facility Maintenance Director removed the wreaths on resident room doors, the Christmas tree on 400 wing, and hanging ornaments in the dining rooms. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • Facility Maintenance Department will be educated on the NFPA guidelines regarding combustible decorations. • A Facility-wide audit of holiday decorations will be conducted by Facility Maintenance Director or designee. Any decorations found not to be in compliance with NFPA guidelines will either be removed or made flame retardant. **Monitoring:** An audit of facility holiday decorations will be completed by the Maintenance Director or designee weekly x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Maintenance Director will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of	1/10/2015
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain required corridor widths in 2 of 6 smoke compartments. The findings were: Observation of the Public Toilet between the 300 & 400 wings at 1:55 PM, the Public Toilet between the 200 & 300 wings at 2:10 PM, and the Dryer Room at 3:17 PM revealed the doors opened into corridor and projected into the corridor ' s required width more than 7 inches when fully opened. Interview of the Maintenance Director confirmed the observed conditions. REFERENCE 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width	K 130		

audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if Intervention(s) are successful.

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K 130	Continued From page 8 of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 mm) into the required width of a stair or landing when the door is fully open.	K 130	**K130: Miscellaneous** **Corrective Actions:** The Maintenance Director ordered and installed new door closers on the two Public Toilet Doors and the one Dryer Room Door that allow the required clearance in egress corridors. **Others Potentially affected:** All residents on the 200, 300 and 400 wings have the potential to be affected by this practice. **Systemic Changes:** • The Maintenance Department will be educated on the NFPA guidelines for door clearance in egress corridors. • A Facility wide audit of doors that open into corridors will be conducted by the Facility Maintenance Director or Designee. Any doors found not to be in compliance will be corrected. **Monitoring:** An audit of doors that swing into egress corridors will be completed by the Maintenance Director or designee weekly x 4 weeks, monthly x 3 months and random thereafter. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	1/16/2015