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	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	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 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 (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 75 certified Medicaid beds with a census of 59.	K 000		
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 staff interview, the facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 1 of 6 smoke compartments. The findings	K 029	**K029: NFPA 101 LIFE SAFETY CODE STANDARDS** **Corrective Actions:** The Facility Maintenance Director installed an appropriate door closer on the "dietician" storage room. **Others Potentially Affected:** All facility residents have the potential to be affected by this practice. **Systemic Changes:** • The Administrator or designee will educate the Facility Maintenance Department on the NFPA requirements for self-closing doors on storage areas. • An audit will be conducted on all storage room doors to ensure that they are compliant with NFPA guidelines. Any areas not found to be in compliance will be addressed.	July 14, 2015

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

NHA 6-25-2015

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.

POC Accepted WA Phone Call with Acting Administrator Connie Lucius on 6/29/15 @ 3:15pm. 34354

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 _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	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 1 were: Observation on 06/03/15 at 12:00 PM revealed the door to the dietician storage room was not provided with a closer. The room was used to store combustible material and was over 50 sqft. At the time of the observation the facility maintenance manager, and the facility administrator acknowledged the door was not provided with a self-closing device. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	**Monitoring:** The Facility Maintenance Director will audit Facility Storage Area Doors 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 050 SS=D	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 document review and staff interview, the facility failed to provide fire drills held at unexpected times and at least quarterly on each shift. The findings were: Document review on 06/03/15 from 11:00 AM to 11:50 AM revealed no record of a fire drill was available for the second shift (6pm-6am) during the first quarter of 2015. Interview with the facility	K 050	**K050: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Actions:** The Facility Maintenance Director scheduled and executed a Facility Wide Fire Drill for the night shift on June 24th, 2015. **Others Potentially Affected:** All facility residents have the potential to be affected by this practice. **Systemic Changes:** • The facility Administrator or designee will educate the Facility Maintenance Department on NFPA requirements for conducting fire drills held at unexpected times and at least quarterly on each shift. • The Facility Maintenance Director will conduct 2 fire drills per month going forward. The first will be conducted on the day shift and the second will be conducted on the night shift. **Monitoring:** The Facility Administrator or designee will audit the number and times of the fire drills monthly x three months and random thereafter.	July 14, 2015

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 _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	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 2 maintenance director verified that no documentation was available. Ref: 2000 NFPA 101, Section 19.7.1.2	K 050	QA: The Facility Administrator or designee 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 076 SS=D	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 store the medical oxygen cylinders separated away from combustible or incompatible materials in 1 of 4 smoke compartments in accordance to NFPA 99. The findings were: Observation on 06/03/15 at 2:45 PM revealed a large wire storage rack with cardboard boxes, and medical oxygen supplies being stored within 3 ft of (17) E cylinders in the oxygen storage room in the Care Center. At the time of the observation the facility maintenance manager acknowledged the items being stored within 3 ft	K 076	**K076: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** The Facility Maintenance Director removed the wire storage rack with cardboard boxes and medical oxygen supplies begin stored in the oxygen storage room in the Care Center. **Others Potentially Affected:** All facility residents have the potential to be affected by this practice. **Systemic Changes:** • The facility Administrator or designee will educate Facility Maintenance Department on NFPA guidelines regarding the storage of combustibles in the Oxygen storage rooms. • The Facility maintenance Director will conduct a facility wide audit on all oxygen storage areas to ensure compliance to NFPA guidelines. Any areas found not to be in compliance will be addressed. **Monitoring:** The Facility Maintenance Director will audit Facility Oxygen Storage rooms weekly x 4 weeks, monthly x 3 months and random thereafter. QA: The Facility Administrator or designee 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.	July 14, 2015

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 _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 3 of the oxygen cylinders. Ref: 2000 NFPA 101, Section 19.3.2.4 1999 NFPA 99, Section 8-3.1.11.2	K 076		
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 that the electrical equipment was in accordance to NFPA 70 in 1 of 6 smoke compartments. The findings were: Observation on 06/03/15 at 2:50 PM revealed the servery janitor's closet electrical panel area was being used for storage within the required 36" workspace. At the time of the observation the facility maintenance manager acknowledged the items being stored within the area. Ref: 2000 NFPA 101, Sections 19.5.1 and 9.1.2 1999 NFPA 70, Table 110.34(a)	K 147	**K147: NFPA 101 LIFE SAFETY STANDARD** **Corrective Action:** The Maintenance Director removed the noted items stored within the required 36 inches of the electrical panel in the janitor's closet. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • The Facility Administrator or designee will educate the Facility Maintenance Department regarding the NFPA guidelines of the required clearance needed around facility electrical panels. • The Facility Maintenance Director will conduct a facility wide audit on all electrical panels to ensure compliance on the 36" workspace requirement. Any areas not found to be in compliance will be addressed. **Monitoring:** The Facility Maintenance Director will audit the clearance around facility electrical panels once per week x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Administrator or designee 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.	July 14, 2015

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 _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	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 the 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. The facility was a fully sprinklered, single story building of Type V (111) construction built in 2007. 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 nursing home building. The facility had a capacity of 28 certified Medicaid beds with a census of 22.	K 000		
K 050 SS=D	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. 18.7.1.2 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to provide fire drills held at unexpected times and at least quarterly on each shift. The findings were: Document review on 06/03/15 from 11:00 AM to	K 050	**K050: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Actions:** The Facility Maintenance Director scheduled and executed a Facility Wide Fire Drill for the night shift on June 24th, 2015. **Others Potentially Affected:** All facility residents have the potential to be affected by this practice. **Systemic Changes:** • The facility Administrator or designee will educate the Facility Maintenance Department on NFPA requirements for conducting fire drills held at unexpected times and at least quarterly on each shift. • The Facility Maintenance Director will conduct 2 fire drills per month going forward. The first will be conducted on the day shift and the second will be conducted on the night shift. **Monitoring:** The Facility Administrator or designee will audit the number and times of the fire drills monthly x three months and random thereafter.	July 14, 2015

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

[signature] — NHA — 6-25-2015

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.

JUN 29 2015
Healthcare Licensing and Surveys

POC Accepted Via Phone Call with Acting Administrator Connie Lucius on 6/29/15 at 3:15pm [signature] 34354

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 _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	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 1 11:50 AM revealed no record of a fire drill was available for the second shift (6pm-6am) during the first quarter of 2015. Interview with the facility maintenance director verified that no documentation was available. Ref: 2000 NFPA 101, Section 18.7.1.2	K 050	QA: The Facility Administrator or designee 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 076 SS=D	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, 18.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to store the medical oxygen cylinders separated away from combustible or incompatible materials in 1 of 4 smoke compartments in accordance to NFPA 99. The findings were: Observation on 06/03/15 at 12:55 PM revealed plastic shelving, medical oxygen supplies, and concentrators stored within 1 ft of (15) E cylinders in the oxygen storage room #558. At the time of the observation the facility maintenance manager, and the facility administrator acknowledged the	K 076	**K076: NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective Action:** The Facility Maintenance Director removed the wire storage rack with cardboard boxes and medical oxygen supplies begin stored in the oxygen storage room in the Care Center. **Others Potentially Affected:** All facility residents have the potential to be affected by this practice. **Systemic Changes:** • The facility Administrator or designee will educate Facility Maintenance Department on NFPA guidelines regarding the storage of combustibles in the Oxygen storage rooms. • The Facility maintenance Director will conduct a facility wide audit on all oxygen storage areas to ensure compliance to NFPA guidelines. Any areas found not to be in compliance will be addressed. **Monitoring:** The Facility Maintenance Director will audit Facility Oxygen Storage rooms weekly x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Administrator or designee 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.	July 14, 2015

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	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	06/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 2 items being stored within 1 ft of the oxygen cylinders. Ref: 2000 NFPA 101, Section 18.3.2.4 1999 NFPA 99, Section 8-3.1.11.2	K 076		
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 that the electrical equipment was in accordance to NFPA 70 in 1 of 4 smoke compartments. The findings were: Observation on 06/03/15 at 1:05 PM revealed the kitchen electrical panel area in the SCU was being used for storage within the required 36" workspace. At the time of the observation the facility administrator acknowledged the items being stored within the area. Ref: 2000 NFPA 101, Sections 18.5.1 and 9.1.2 1999 NFPA 70, Table 110.34(a)	K 147	**K147: NFPA 101 LIFE SAFETY STANDARD** **Corrective Action:** The Maintenance Director removed the noted items stored within the required 36 inches of the electrical panel in the janitor's closet. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • The Facility Administrator or designee will educate the Facility Maintenance Department regarding the NFPA guidelines of the required clearance needed around facility electrical panels. • The Facility Maintenance Director will conduct a facility wide audit on all electrical panels to ensure compliance on the 36" workspace requirement. Any areas not found to be in compliance will be addressed. **Monitoring:** The Facility Maintenance Director will audit the clearance around facility electrical panels once per week x 4 weeks, monthly x 3 months and random thereafter. **QA:** The Facility Administrator or designee 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.	July 14, 2015