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

PRINTED: 06/18/2015
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 ______	C 06/04/2015

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
F 000	INITIAL COMMENTS On 6/1/15 - 6/4/15 a recertification survey was conducted. In addition, a complaint was investigated prompted by complaint intake WY00002027. The following common abbreviations are used throughout this document: ADL - Activity of Daily Living BIMS - Brief Interview for Mental Status CAA - Care Area Assessment CNA - Certified Nurse Aide DON - Director of Nursing MAR - Medication Administration Record LPN - Licensed Practical Nurse MDS - Minimum Data Set PRN - Pro re Nata (as needed) RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F221 Physical Restraints** **Corrective Actions:** Resident #42 was assessed for physical device use on 06/03/2014. Resident #42 has been assessed for risks and benefits of a recliner and side rail use, by the IDT and Safety Committee. The MDS is appropriately coded for restraint use for resident #42. The resident's care plan has been updated to reflect current status of physical restraints.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to assess the use of physical restraints for 2 of 2 sample residents (#42, #62) who utilized physical	F 221	Resident #62 uses a pommel cushion and lap buddy. The CAA has been modified to address the risks of using any restraint devices, including risks versus benefits. The resident's care plan has been updated to reflect current status of physical restraints. **Others Potentially Affected:** No other residents were identified as having been affected by this practice.	July 14, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 7-6-2015

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.

WY Dept of Health POC accepted. DOC = 7/14/15 - MSJ lgt per Michael Spriggs, (WHA) on 7/9/15 @ 3:15pm. Janee Colby, OSEIL

JUL 07 2015
Healthcare Licensing and Surveys

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GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 221	Continued From page 1 restraints. The findings were: 1. Review of the 3/24/15 quarterly MDS assessment for resident #42 showed the resident was cognitively impaired with a BIMS score of 3 out of 15 and had diagnoses that included Alzheimer's dementia. Further review of the MDS showed the resident was not coded as having a restraint. The following concerns were identified: a. Observation on 6/1/15 at 11:30 AM showed the resident was sitting in the electric recliner in his/her room. The recliner was laid back and the resident's legs were elevated on the foot rest and the resident's eyes were closed. The recliner control was lying on the ground out of reach of the resident. Continued observation at that time showed the resident had a side rail applied to the outside of the bed and the other side was positioned next to the wall. The device was designed to have gaps between the bars which were large enough for the resident to possibly entrap a limb. The gaps were measured, and there were two gaps between the bars that were 4 inches by 26 inches in size. b. Observation of the resident on 6/4/15 at 9:58 AM showed the resident was in the electric recliner in his/her room. The recliner was laid back and the resident's legs were elevated on the foot rest and the resident's eyes were closed. The recliner control was lying on the ground out of reach of the resident. c. Review of the physical device assessment signed on 6/3/15 showed the resident had a history of falls, impaired mobility, and impaired judgement. Continued review showed the resident's suggested devices included a bed alarm, recliner, and side rails. The assessment determined the devices were restraints; however, safety of the devices was not assessed.	F 221	Systemic Changes: Residents that use mechanical restraints, including new admissions and residents with a significant change will have a safety assessment completed and a quarterly review to determine the necessity and safety of the restraint. Monitoring: The Restorative RN or designee will audit 5 residents per unit weekly for 6 weeks to assure residents using mechanical restraints have a quarterly safety assessment completed. QA: The Restorative RN or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 221	Continued From page 2 d. Interview with CNA #1 on 6/9/15 at 5:42 PM revealed the resident was placed in the recliner several years ago because s/he was trying to crawl out of bed. Further interview at that time revealed the resident could walk on "good days." e. Interview with the DON on 6/4/15 at 10:40 AM revealed the resident would attempt to get up without assistance and those attempts to get up resulted in falls. Further interview at that time revealed the recliner and the side rail were not coded as restraints; however, "they should have been." 2. Review of the 3/2/15 annual and the 5/28/15 quarterly MDS assessments showed resident #62 had diagnoses that included Down Syndrome and convulsions. The assessment further showed the resident was moderately impaired for daily decision making, required extensive to total assistance for ADLs, and utilized a physical restraint to prevent rising from the chair daily. Observation on 6/1/15 at 4:48 PM showed CNA #2 and CNA #3 assisted the resident from the bed into the wheelchair. Once in the wheelchair the aides placed a pommel cushion between the resident's legs and then placed a lap buddy restraint (a long cushion placed across the resident's legs and through the armrests to restrain rising) onto the wheelchair. At that time CNA #2 revealed the resident had poor body control and these cushion devices were used to prevent the resident from falling out of the chair. The following concerns were identified: a. Review of the CAA generated from the 3/2/15 annual MDS assessment showed the resident utilized the restraint daily and identified the benefits; however, it failed to identify any risks to the resident associated with the use of	F 221		

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F 221	Continued From page 3 restraint. b. Interview with the Director of Clinical Services on 6/4/15 at 4:10 PM verified she was unable to locate any completed assessment to show the risks and benefits of using the restraint devices. 3. Review of the facility policy "Restraints Mechanical" revised in August 2013 showed "...Residents using a mechanical restraint will have a quarterly review to determine the necessity of the restraint..." F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to maintain dignity for 1 of 6 sample residents who required assistance while dining (#62). The findings were: Review of the 3/2/15 annual and the 5/20/15 quarterly MDS assessments showed resident #62 had diagnoses that included Down syndrome and convulsion. The assessment further showed the resident was moderately impaired for daily decision making, was unable to make him/herself understood, had absence of spoken words, and required total assistance with eating. Review of the 3/6/15 care plan approach for eating showed the resident required extensive assistance and	F 221 F 241	**F241 Dignity and Respect of Individuality.** **Corrective Actions:** Resident #62 receives supervision and assistance during meal time to facilitate oral intake and a dignified meal time. **Others Potentially Affected:** Residents requiring assistance at meals have the potential to be affected. **Systemic Changes:** Education to staff will be provided in an All-Staff meeting by July 8, 2015 regarding residents that require assistance with eating will not be served food until staff are available to assist them with their meal. The Director of Nursing will assure training is completed by July 14, 2015. **Monitoring:** The Unit Managers or designee will audit 5 residents weekly for 6 weeks to assure those residents that require assistance with eating are not served food until staff is available to assist them with their meal.	July 14, 2015

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F 241	Continued From page 4 could "become frustrated when eating because [s/he] wants to try on [his/her] own but is unable to manage the food." The following concerns were identified: a. Observation on 6/1/15 during the lunch meal at 12:06 PM revealed the resident was seated at an isolated table with a small bowl of pureed food on the table before him/her. The resident was making grunting and crying noises and appeared to be struggling to reach the food. At that time residents at nearby tables were being served their food by the staff and were eating while the resident sat off alone and was unable to eat the food that was set out before him/her. Although the resident appeared frustrated as indicated by the grunting and crying sounds, no staff members came to check on the resident until 12:32 PM (27 minutes later) when the remainder of the resident's meal was served and the resident was assisted to eat. b. Interview with CNA #2 on 6/1/15 at 12:32 PM revealed that the dietary staff usually set out the cold food items at the tables early as part of the set up for meals. The aide then verified the resident was unable to eat without assistance and sat away from the other residents due to behaviors such as spitting out food. c. Observation on 6/2/15 at 6:03 PM during the evening meal showed the resident was seated at an isolated table by himself/herself and was making crying noises and struggling movements. There was a small bowl of pureed food placed on the table. The resident was making crying noises and struggling movements towards the food. There were nine staff members in the dining room at that time serving resident meals. At 6:17 PM CNA #1 placed two cups of juice on the resident's table and walked away. It was not until 6:23 PM (20 minutes later) that CNA	F 241	QA: The Unit Managers or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 241	Continued From page 5 #1 came over to assist the resident with eating his/her meal. d. Interview with the DON on 6/4/15 at 12:10 PM verified the dining situation for resident #62 was not dignified. The food should be served at the time staff are available to assist the resident.	F 241	F 248 Activities Corrective Actions: Residents #10, #45, #48 have been assessed for activity preferences, including musical interests, reading materials, religious service attendance, group activities or 1:1's.	
F 248 SSED	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review the facility failed to develop an individualized and ongoing program of activities to meet resident needs for 3 of 14 sample residents (#10, #45, #48). The findings were: 1. Review of the 2/20/15 annual MDS assessment showed resident #10 was severely cognitively impaired, and totally dependent on the physical assistance of 1-2 persons for all ADLs. The resident had behavioral symptoms that were not directed at others, such as screaming or disruptive sounds, daily and those behaviors significantly interfered with the resident's participation in activities or social interactions. The staff assessment of the resident's activity preferences showed the resident preferred reading books, newspapers or magazines, listening to music, participating in favorite	F 248	Activity care plans for Residents #10, #45, and #48 have been updated to reflect the current and past interests and preferences for participation in activities. Others Potentially Affected: All residents have the potential to be affected by this practice. Systemic changes: Resident care plans will include activities preferred by the resident and what the resident can do if the activity does not meet their individual need. Residents requiring one on one activities will be care planned and offered three times a week. A new Activity Assessment tool will be used for all residents and updated annually or with a significant change. Education to the Activity staff will be completed by July 8, 2015 and will include proper documentation on resident participation. Monthly meetings are held for residents to recommend activities they would like included.	July 14, 2015

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F 248	Continued From page 6 activities, doing things with groups of people, spending time outdoors, and participating in religious activities or practices. Review of the care plan for activities, last updated 8/13/14 showed the resident's activity participation had "decreased due to a change in residents health as [s/he] is no longer walking around independently as [s/he] previously did, and [s/he] is now reliant on staff for her mobilization in a chair." The following concerns were identified: a. Observation on 6/1/15 at 3:40 PM and again on 6/3/15 at 2:10 PM showed the resident was laying in bed in his/her room. The resident's room was located near the end of a long hall, away from the main milieu and the nurses' station. On both occasions, the resident was awake and making loud sounds such as wailing, snuffling, and saying "Cuckoo, cuckoo." No staff were in the area. b. Review of the resident's activity assessment showed it was completed on 9/2/11. The assessment showed the resident didn't "sit still long enough to do an activity..." According to notations on the assessment, it had been reviewed several times since then; the most recent review occurred 5/17/14. The assessment noted the resident liked music, but provided no details about the type of music the resident enjoyed or how s/he liked to listen to it. There was no information on the assessment about what the resident's favorite activities were, what sort of materials s/he liked to read, or how s/he preferred to participate in religious services or practices. c. Review of the activities care plan goals, most recently updated 8/13/14, showed the resident got "upset in crowds" would "yell out," this was "disruptive to the other residents," and the facility would "offer [resident] one to ones once a week." Further review showed the	F 248	Monitoring: The Activity Director or designee will audit 5 resident care plans for 6 weeks to assure the care plan reflects specific activities residents prefer and what options they have when individual resident activity needs are not addressed. Residents requiring one on one activities are offered three times a week. QA: The Activity director or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 248	Continued From page 7 activities care plan had been reviewed on 1/16/15, and no changes were made to the approaches or goals. d. Interview with the activities director on 6/4/15 at 3:42 PM revealed one visit per week was not sufficient. e. Review of the care plan for behaviors, last updated 11/20/14, showed the resident had behaviors that were disruptive. These behaviors were manifested by verbal outbursts, screaming and agitation, and staff were to report pain indicators, offer conversation, "visit with [the resident] when [s/he] is agitated" and "engage [the resident] in an activity when [s/he] is upset..." The care plan did not indicate what sort of activity the resident should be engaged in when upset. f. Review of activity documentation for the month of May 2015 showed visits were recorded on 10 days of the month. Five of those visits primarily consisted of reading to the resident, and two included listening to music and moving the resident's hands. However, 3 of the visits recorded were "visited with [resident] during meal time - assisted [him/her] with" the meal. One to one visits were the only activity attendance documented for the month. There were no other activities, such as favorite or religious activities documented. g. Interview with the activity director on 6/4/15 at 3:42 PM revealed he had been in the position since October 2014. He confirmed visiting/talking with residents while assisting them with their meals was expected of all staff and should not be recorded as an activity. He further confirmed the resident's activity assessment had not been thoroughly updated since 9/2/11. The activity director explained the activity program on the secure unit was a "work in progress" and new activity assessments were being done for	F 248		

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F 248	Continued From page 8 residents as they came up for review in the MDS schedule. 2. Review of the 4/16/15 significant change MDS assessment for resident #48 showed the resident was able to make him/herself understood and usually understood others. Continued review showed the resident had moderately impaired cognition with a BIMS score of 11 out of 15. Review of the activity assessment dated 10/21/14 showed the resident liked to watch sports shows and football, liked music, video games, puzzles, dogs and cooking "anything and everything." The following concerns were identified: a. Observation on 6/1/15 at 4:40 PM showed the resident was in his/her room, sitting in the wheelchair, with the television on a black and white movie. The resident was not engaged in watching the television. b. Observation on 6/2/15 at 9:10 AM showed the resident was in his/her room, sitting in the wheelchair with the television on a black and white movie. The resident was not engaged in watching the television. c. Observation on 6/3/15 at 1:45 PM showed the resident was in his/her room, sitting in the wheelchair, with the television on the weather channel. The resident was not engaged in watching the television. d. Review of activity attendance documentation for the month of May 2015 showed the resident was documented as "watching TV" for an activity 42 times. e. Interview with the resident on 6/3/15 at 1:45 PM revealed the facility did not have activities for younger people and s/he kept the television on for "background noise" to keep from getting lonely. Continued interview at that time revealed the resident was not looking forward to	F 248		

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F 248	Continued From page 9 any of the upcoming activities. 3. Review of the 3/19/15 significant change MDS assessment for resident #45 showed the resident was cognitively intact with a BIMS score of 15 out of 15. Review of the 12/15/14 recreation assessment showed the resident liked country western music, "forensic files" television, woodwork, dogs, committees/clubs, outings, discussion groups, current events, quiet/personal time, and having visitors. The following concerns were identified: a. Observation on 6/1/15 at 4 PM showed the resident was in his/her room, sitting in the wheelchair, with the television on. b. Review of activity attendance documentation for the month of May 2015 showed the resident was documented as "watching TV" for an activity 37 times. c. Interview with the resident on 6/3/15 at 2 PM revealed the facility does not have much for the younger residents to do. Continued interview at that time revealed the facility should "listen to what the residents like [to do] and not what they choose [to provide for activities]." 4. Interview with the activity director on 6/4/15 at 3:30 PM confirmed the facility had limited activities that met the needs of younger residents.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	F 279 Develop Comprehensive Care plans **Corrective Actions:** Resident #8 has a care plan to address pain. Resident #10 has a care plan to address pain. Resident #62 has a care plan that addresses pain indicators, that the resident grinds her teeth when upset, and the use of the baby doll to calm resident's behaviors.	July 14, 2015

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F 279	Continued From page 10 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review the facility failed to develop care plans with resident specific problems, goals, and interventions in a variety of areas for 3 of 13 sample residents (#8, #10, #62). The findings were: 1. Review of the 6/5/15 quarterly MDS assessment for resident #8 showed the resident had diagnoses that included arthropathy and edema, and reported almost constant pain, described as 8 on a scale of 1 to 10 with 10 being the worst pain, that interfered with sleep and activities. The following concerns were identified: a. Review of the resident's care plan showed no care plan for pain. b. Interview with the MDS coordinator on 6/4/15 at 10:55 AM verified the resident did not have a care plan for pain. 2. Review of the 2/20/15 annual MDS	F 279	Others Potentially Affected: All residents have the potential to be affected by this practice. Systemic changes: Residents will be assessed for pain every shift. All residents will have a care plan to identify pain issues and interventions to be used along with goals. Licensed nurses will be educated by the Director of Nursing on or before July 8, 2015 on the process of resident pain assessments completion every shift. Monitoring: The Unit Managers or designee will audit 5 residents' care plans per hall weekly for 6 weeks to assure residents have a care plan that identifies interventions for pain and includes clear goals. QA: The Unit Managers or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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	53A049	A. BUILDING _____ B. WING _____	C 06/04/2015

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F 279	Continued From page 11 assessment showed resident #10 had diagnoses that included chronic pain, and triggered for further assessment of pain. Review of Section V of the same MDS assessment showed the facility decision to include a care plan for pain in the resident's care plan. The following concerns were identified: a. Review of the care plan showed no care plan for pain. b. Review of the physician order recapitulation, signed 2/5/15, showed the resident received two Tylenol (a pain medication) 500 mg tablets (total dosage = 1000 mg) three times daily. c. Interview with the MDS coordinator on 6/4/15 at 10:55 AM verified the resident did not have a care plan for pain. 3. Review of the 3/2/15 annual and the 5/28/15 quarterly MDS assessments showed resident #62 had diagnoses that included Down syndrome and convulsions. The assessment further showed the resident was moderately impaired for daily decision making, was unable to make him/herself understood, had absence of spoken words, and required extensive to total assistance with ADLs. Observation on 6/3/15 at 10:25 AM showed the resident was holding a baby doll, was smiling and appeared to be content. On 6/4/15 at 9:30 AM the resident was observed again with the baby doll and smiling. During interaction with the resident at that time, the resident began to noticeably grind his/her teeth. The following concerns were identified: a. Review of the care plan showed a problem related to disruptive behaviors with the most current date shown as 2/24/15. This care plan showed the resident had vocal outbursts with grunting and crying which affected those around	F 279		

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F 279	Continued From page 12 him/her. The approaches for this problem included nursing to identify triggers and/or underlying causes of behavior, nurse aides to record behaviors and to report pain, all staff were to report pain indicators. The plan failed to identify specifics such as what the pain indicators were, or what the baby doll was used for. b. The teeth grinding behavior was only mentioned in the behavior care plan under the column titled "evaluation" and it was dated 12/1/14. This evaluation note showed the resident grinds his/her teeth when upset; however, there was not any intervention or care plan developed to address the behavior or the effect on the residents teeth. c. Interview with CNA #4 on 6/4/15 at 9:35 AM revealed the resident grinds his/her teeth "all of the time." The CNA did not think it meant anything or that the resident was in anyway trying to communicate with the teeth grinding behavior. It was not something she recorded or reported on to the nurses. d. Interview with the activity director on 6/3/15 at 10:30 AM revealed he was not aware of a baby doll and was not sure of the reason for the use. He further verified it was not part of an activity care plan. e. Review of the resident care plan last reviewed by the multidisciplinary team on 5/21/15 failed to mention the baby doll and failed to identify pain as a problem with clear goals and interventions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282	**F 282 Services by qualified persons/per care plan.** **Corrective Actions:** Resident #62's protective sleeves were applied on day 2 of the survey. Resident #62 uses gerl sleeves to protect frail skin.	July 14, 2015

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F 282	Continued From page 13 care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the care plan was implemented for 1 of 13 sample residents (#62). The findings were: Review of the 5/28/15 quarterly MDS assessments showed resident #62 had diagnoses that included Down Syndrome and convulsions. The assessment further showed the resident was moderately impaired for daily decision making, and required extensive to total assistance for ADLs. Review of the care plan for ADLs showed an entry dated 5/21/15 for the use of geri-sleeves (removable protective sleeves) and safe positioning when in the wheelchair. The following concerns were identified: a. During observation on 6/1/15 at 4:48 PM the resident was transferred using a mechanical lift from the bed to the wheelchair. During this transfer the resident's elbows and lower arms were exposed and noted to be scratched and scabbed and the skin was whitish and appeared flaky. At that time CNA #2 stated the skin was sometimes injured during transfers where the sling came into contact with the resident's arms. b. Observation on 6/2/15 at 6 PM showed the resident was seated in a wheelchair in the main dining room, and both arms were uncovered. c. On 6/3/15 at 10:20 AM observation showed the resident was up in the wheelchair near the nurses' station with geri-sleeves on both arms. Interview with CNA #4 at that time verified the resident was to wear the sleeves daily to protect her skin.	F 282	**Others potentially affected:** No other residents were identified as having been affected by this practice. **Systemic changes:** Residents that require protective clothing such as geri sleeves will wear them daily per care plan to protect their skin. The nursing staff will be educated on or before July 8, 2015 on following resident care plans and application of protective skin products. **Monitoring:** The Unit Managers or designee will audit 5 residents per unit for 6 weeks to assure protective garments are in place per care plan. **QA:** The Unit Managers or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview and staff interview, the facility failed to regularly assess residents for pain for 5 of 12 sample residents (#8, #10, #45, #48, #62) with pain. The findings were: 1. Review of the 6/5/15 quarterly MDS assessment showed resident #8 had diagnoses that included non-Alzheimer's dementia, arthropathy and edema, was moderately cognitively impaired, and reported almost constant pain, described as 8 on a scale of 1 to 10 with 10 being the worst pain, that interfered with sleep and activities. The following concerns were identified: a. Review of the resident's care plan showed no care plan for pain. b. Review of the resident's MAR for May 2015 and June 2015 showed the resident did not receive any regularly scheduled pain medications. c. Further review of the resident's MAR and nurses' notes for May 2015 and June 2015 showed no regularly scheduled assessment of the resident's pain. d. Interview with the MDS coordinator on 6/4/15 at 10:55 AM verified the resident did not	F 309	**F309 Provide care/services for highest well being** **Corrective Actions:** Residents #8, #10, #45, #48, and #62 are being assessed for pain every shift, using a Faces Pain Scale or a PAINAD scale. Resident care plans have been updated for pain in resident's #8, #10, #45, #48, and #62. **Others potentially affected:** All residents have the potential to be affected by this practice. **Systemic changes:** All residents will be assessed every shift for pain. Staff will use the PAINAD scale for those residents that cannot verbalize their needs. Licensed nurses will be educated by the Director of Nursing on or before July 8, 2015 on the process of resident pain assessments completion every shift. **Monitoring:** The Unit Managers or designee will audit 5 residents per unit for 6 weeks to assure residents are assessed for pain each shift. **QA:** The Unit Managers or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 309	Continued From page 15 have a care plan for pain. She stated there were no scheduled pain assessments of residents; that pain assessments were only triggered in the electronic charting system when pain medications were administered. Additionally, she stated staff had received no training in assessing pain in residents suffering from dementia. 2. Review of the 2/20/15 annual MDS assessment showed resident #10 had diagnoses that included Alzheimer's disease and chronic pain, and triggered for further assessment of pain. Review of Section V of the same MDS assessment showed the facility decision to include a care plan for pain in the resident's care plan. The following concerns were identified: a. Review of the care plan showed no care plan for pain. b. Further review of the resident's MAR and nurses' notes for May 2015 and June 2015 showed no regularly scheduled assessment of the resident's pain. c. Interview with the MDS coordinator on 6/4/15 at 10:56 AM verified the resident did not have a care plan for pain. She stated there were no scheduled pain assessments of residents; that pain assessments were only triggered in the electronic charting system when pain medications were administered. Additionally, she stated staff had received no training in assessing pain in residents suffering from dementia. 3. Review of the 3/19/15 significant change MDS assessment showed resident #45 was cognitively intact with a BIMS score of 15 out of 15 and had diagnoses that included chronic pain, status post-foot amputation, restless leg syndrome, anxiety disorder, and depression. Further review showed the resident reported frequent pain with a	F 309		

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F 309	Continued From page 16 severity of 8 on a scale of 1 to 10 with 10 being the worst pain. The following concerns were identified: a. Review of the May 2015 MAR showed the resident received Norco 10 mg-325 mg (an opiod pain medication) 1 tablet by mouth PRN for pain 20 out of 31 days. b. Review of the nurses' notes for May 2015 showed pain was only evaluated at the times the resident requested pain medication. c. Interview with the resident on 6/3/15 at 2:00 PM revealed the resident had "a lot of pain" and s/he had to ask for pain medication. Further interview at that time revealed the nurses didn't ask if the resident had pain unless the medication was requested and it would have helped to have medication routinely scheduled because the pain interrupted his/her sleep. 4. Review of the 4/16/15 significant change MDS assessment showed resident #48 had moderately impaired cognition with a BIMS score of 11 out of 15 and had diagnoses that included cardio-vascular accident, non-Alzheimer's dementia, and depression. Further review showed the resident reported almost constant pain with a severity of 6 on a scale of 1 to 10 with 10 being the worst pain. The following concerns were identified: a. Review of the May 2015 MAR showed the resident received PRN pain medication 16 out of 31 days. b. Review of the nurses' notes for May 2015 showed pain was only evaluated at the times the resident requested pain medication. 5. Review of the 5/28/15 quarterly MDS assessment showed resident #62 had diagnoses that included Down syndrome and convulsions.	F 309		

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F 309	Continued From page 17 The assessment further showed the resident was moderately impaired for daily decision making, was unable to make him/herself understood, had absence of spoken words, and required extensive to total assistance with ADLs. Review of the May and June 2016 MARs showed the resident had physician orders for pain medications: Tylenol 2 tabs 500 mg every 4 hours as needed (PRN) for pain rated at 4-7 out of 10, and Tylenol 2 tabs 325 mg PRN for pain at 1-3 out of 10. According to the MARs the medications were not administered during that time frame. Review of the resident's care plan with a review date of 5/21/15 showed the resident had communication problems and was unable to make his/her needs known. The approaches included "assess for unmet needs such as pain..." The 5/21/15 care plan also included a problem area related to behaviors. The resident displayed behaviors including "yelling out...grunts...crying...sobbing." The approaches related to this area included assess/treat pain, identify triggers, and report pain indicators. The following concerns were identified: a. The care plan did not identify the scale to be used in assessing pain for this resident who was unable to express words. Additionally, the pain indicators were not described. b. Review of the May and June 2015 nurses' notes failed to show any shift assessments to assess the resident for pain. c. Interview with the DON on 6/4/15 at 12:10 PM revealed a pain assessment should be done by the nurse on each shift to assess possible pain for this resident. 6. Interview with the DON on 6/4/15 at 10:40 AM revealed resident pain was assessed quarterly, but the standard would be every shift.	F 309		

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F 367 F 367 SS=D	Continued From page 18 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, menu review, and diet manual review, the facility failed to ensure therapeutic diets were provided as ordered for 1 of 8 residents (#26) with mechanical textured diets. The findings were: Review of the medical record showed resident #26 had diagnoses that included Alzheimer's dementia. The 2/18/15 dietary note and physician order showed the resident required assistance with eating and the diet order was for pureed texture foods with ground meats including gravy/sauce on all ground meats. The following concerns were identified: a. Observation on 6/3/15 at 5:45 PM showed cook #1 began the meal service for the secure unit residents. The resident was served 8 ounces of turkey pot pie, and 1/2 cup of stewed tomatoes. The texture of the meal had not been manipulated and was the same as the regular diet. The pieces of turkey in the pot pie were approximately 1 inch by 1/2-1 inch in size. The tomatoes were soft, however, had not been cut down in size. Each piece was approximately 2 inches in diameter. Interview with the cook at that time verified this was acceptable for the mechanical texture diet as far as he was aware. b. Interview with LPN #1 on 6/3/15 at 5:55 PM verified when she observed the food, the texture was not appropriate for the resident. The	F 367 F 367	F367 Therapeutic diet **Corrective Actions:** The meat and tomatoes were cut down to the appropriate size for residents needing mechanical soft diets. **Others Potentially Affected:** Residents having physician orders for mechanically altered diet have the potential to be affected. **Systemic Changes:** An in-service will be done for education to the dietary staff related to preparation of mechanical diets on July 2, 2015. **Monitoring:** The Dietician or designee will audit 5 residents weekly for 6 weeks to assure residents are served the correct texture of food for mechanically altered diets. **QA:** The Dietician or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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F 367	Continued From page 19 nurse then spoke with the cook to replace the meal. c. Review of the menu for 6/3/15 showed the mechanical texture diet was the same as the regular diet. It failed to include any instruction for changing the texture of any foods. d. Interview with the registered dietitian (RD) on 6/3/15 at 6 PM verified the residents who received mechanical ground diets needed to have the turkey in the pot pie and the tomatoes further cut/ground. The RD verified she had not provided formal education related to preparation of mechanical diets. Additionally, the menu and recipes were in a development phase and did not include specific instructions. The RD proceeded to instruct the servers that evening, to ensure proper texture for the other residents who had mechanical texture diet orders. e. Review of the diet manual information used by the facility ("Nutrition Care Manual" Academy of Nutrition and Dietetics, 2014) showed "casseroles with rice or large chunks" were not recommended for mechanically altered diets.	F 367		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Food procure/Store/prepare/serve - Sanitary Corrective Actions: The slicer and kitchen area were cleaned. Others Potentially Affected: All residents have the potential to be affected by these actions.	July 14, 2015

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F 371	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 3 of 5 food storage/preparation areas (the memory care kitchen, the main dining room kitchen, and the 300 hall pantry). The findings were: 1. Observation on 6/1/15 at 11:16 AM and again on 6/3/15 at 4:43 PM showed the following items in the memory care kitchen were in need of cleaning: a. The electric slicer had bits of food particles stuck on the blade and in its crevices. b. The freezer in the memory care kitchen had spilled liquid and food crumbs on the bottom shelf. 2. Interview with cook #1 on 6/3/15 at 4:27 PM revealed he had been working in the kitchen for 8 weeks and he not been trained on how to properly clean the electric slicer. 3. Observation on 6/1/15 at 12:05 PM showed the ice machine in the 300 Hall Pantry had hard water build-up on the exterior and interior as well as a brown liquid splattered inside the ice machine. Interview with the registered dietitian (RD) on 6/1/15 at 11:16 AM revealed she was unsure when maintenance last provided service on the ice machine. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil	F 371	Systemic Changes: Education will be done on July 2, 2015 regarding cleaning of the slicer and cleaning schedules. A new ice machine is on order and will be on a preventative maintenance schedule. Dishes that are stained will be discarded and replacements were ordered on June 22, 2015. Education and competencies will be done regarding the test strips used for sanitizing solutions. Monitoring: The Dietician or designee will audit the kitchen weekly for 6 weeks to assure surfaces are clean to sight and touch. QA: The Dietician or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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 end/or termination of monitoring if intervention(s) are successful.	

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	53A040	A. BUILDING _____ B. WING _____	C 06/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2008 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 371	Continued From page 21 accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 4. Observations in the main dining room kitchen on 6/1/16 at 11:30 AM showed the steam table cutting board was visibly stained and scored on the surface. In addition, observations on 6/3/16 at 4:43 PM showed the clean dish storage rack contained four small bowls and one divided plate that were visibly stained with brownish coloring. According to Food Code 2013, U.S. Public Health Service, 4-101.11: Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be... (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. 5. Observations in the main dining room kitchen on 6/3/16 at 5:25 PM showed the quaternary ammonia solution used for cleaning surfaces in the kitchen was not at an acceptable level when tested (less than 100 parts per million (ppm). Interview with the RD at that time verified the solution was too weak and that a system was not in place for testing the sanitizer solution routinely. Interview with cook #1 on 6/1/16 at 4:42 PM revealed he did not know where the test strips for testing the sanitizer solution could be located and he had not been trained on this process/procedure. Review of the product label for the "Oasis 146 multi- quat" sanitizer showed a concentration of 150- 400 ppm was needed to	F 371		

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

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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 _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2000 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 371	Continued From page 22 sanitize surfaces. According to Food Code 2013, U.S. Public Health Service, 4-702.11: "Before Use After Cleaning, UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning." According to Food Code 2013, U.S. Public Health Service, 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;"	F 371		
F 441 65=E	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	F 441	**F441 Infection Control** **Corrective Actions:** Non-permeable jackets with long sleeves were purchased for the laundry personnel to use when sorting soiled laundry. Resident #3 receives appropriate catheter care during transfer, pericare, mobility, and other activities of daily living. **Others Potentially Affected:** No residents were affected by this practice. **Systemic Changes:** Laundry personnel will have non-permeable jackets supplied for protection when sorting soiled laundry. Laundry staff will be educated on the use of long-sleeve non permeable jackets when working with soiled linens. Education to nursing staff to include proper handling of catheter bags per facility protocol. Infection Control education will be completed on or by July 8, 2015.	July 14, 2015

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	53A049	A. BUILDING _____ B. WING _____	C 06/04/2015

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
F 441	Continued From page 23 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. (o) 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 policy and procedure review the facility failed to ensure infection prevention practices were followed by staff for 1 of 1 sample resident (#3) with a urinary catheter. In addition, the facility failed to ensure appropriate personal protective equipment (PPE) was available to laundry staff for infection prevention and control in 1 of 1 laundry room. The findings were: 1. Observation on 6/1/15 at 3:50 PM showed resident #3 was transferred from a recliner to a wheelchair with the use of a mechanical sit-to-stand lift. The resident had a suprapubic catheter in place and the drainage bag was connected during transfer. The following concerns were identified: a. CNA #5 and RN #1 assisted the resident by placing the sling behind the resident and connected it to the lift. CNA #5 removed the catheter bag with an ungloved hand and lifted it above the level of the resident's bladder. Observation of the catheter bag tubing at that	F 441	Monitoring: The Director of Nursing or designee will audit 5 transfers of residents with catheters for proper handling. Laundry personnel will have protective non-permeable protection when sorting potential contaminated laundry. QA: The Director of Nursing or designee will report audit results to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2000 LARAMIE STREET TORRINGTON, WY 82240

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F 441	Continued From page 24	F 441		

time showed there was urine in the tubing that when lifted, flowed backwards in the tubing.

b. Interview with the DON on 6/4/15 at 10:40 AM revealed catheter bags should not be lifted above the height of the bladder.

c. Review of the facility policy "Closed Urinary Drainage System (Foley Catheter) Guidelines" revised in June 2014 showed "Guidelines/Strategies:...10) Maintain drainage bag below the level of the bladder..."

2. Observation of the dirty linen area of the laundry room on 6/4/15 at 9:45 AM showed the staff used a cloth-type lab coat for handling contaminated linen items. The following concerns were identified:

a. Interview with the housekeeping manager on 6/4/15 at 9:45 AM revealed the facility did not separate out contaminated items. Continued interview revealed the staff was to wear the cloth lab coat when handling contaminated linen, and blood or body fluids could perfuse the fabric and contaminate the employee through the lab coat and allow for indirect transmission of infectious agents.

b. Interview with the DON on 6/4/15 at 10:40 AM revealed the laundry staff should be using non-permeable PPE when coming in contact with contaminated linen.

c. Review of the facility policy "Laundry and Linen Policy" revised in April 2014 showed "4. Protecting employees during sort process; a. PPE/protective barriers including fluid resistant gowns or aprons, gloves, and makes[sic]/face protection, and hand hygiene facilities shall be made available to personnel who sort laundry/work with soiled laundry..."