Department of Health and Human Services
Centers For Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
53A049	A. Building B. Wing	08/12/2015

Name of Facility	Street Address, City, State, Zip Code
GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0221 Reg. # 483.13(a) LSC	Correction Completed 07/14/2015	ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 07/14/2015	ID Prefix F0248 Reg. # 483.15(f)(1) LSC	Correction Completed 07/14/2015
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 07/14/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/14/2015	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 07/14/2015
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 07/14/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TB 9/17/15			8/17/15
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	

Followup to Survey Completed on: 06/04/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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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 _____	R 08/12/2015

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{F 000}	INITIAL COMMENTS	{F 000}	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.	
{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 and staff interview, the facility failed to ensure pain assessments were completed for 4 of 6 sample residents (#8, #10, #100, #103) with pain. The failure was related to documentation of routine pain assessments, administration of treatments when pain was identified, and timely re-evaluation of pain medication administration. The findings were: 1. Review of the July and August 2015 MARs showed the following concerns for resident #8: a. Review of the evening pain assessments for 7/18, 7/22, 7/23, 7/27, and 7/28 showed the resident reported pain of 5/10. Continued review of the MAR and the nursing progress notes failed to show any treatments were provided. b. Review of evening pain assessments for 8/2 and 8/11 showed the resident reported pain of 5/10. Continued review of the MAR and the corresponding progress notes failed to show any treatments were provided.	{F 309}	**F309: Provide Care/Services for Highest Well Being** **Corrective Actions:** The facility has completed routine Pain Assessments on Residents #8, #10, #100, and #103. Routine pain assessments are ongoing. Resident's #8, #10, #100, and #103 are receiving pain interventions as indicated to manage individual perceptions of pain. Resident's #8, #10, #100, and #103 are receiving timely re-evaluation of pain medication interventions. Pain assessments, pain medication administration, and re-evaluation of pain medication efficacy are being documented in the resident's electronic medical record.	09/03/15

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

Michael Speidel — Administrator — 8/27/15

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.

RECEIVED
Wyoming Department of Health
AUG 27 2015
Healthcare Licensing and Surveys

Accepted on 9/9/15 w/ no changes by Lori Ruegg and Shaylyn Todd Spoke w/ Michael Speidel 9/10/15

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{F 309}	Continued From page 1 c. Review of the July 2015 MAR and the nurse's notes showed on 7/25/15 at 10:59 PM the resident was administered PRN Tylenol for pain rated at 7/10. The re-evaluation was documented as "effective" on 7/26/15 at 1:24 AM (2 hours and 23 minutes later). d. Interview with the DON on 8/12/15 at 4:30 PM verified no treatments for these pain assessments were documented. In addition, the DON verified the time frame between administration of a PRN pain medication and the re-evaluation for effectiveness was to be completed within 1 hour. 2. Review of the August 2015 MAR showed resident #10 had a pain assessment completed on the evening shift of 8/10/15 which identified a pain level of 3/10. The time of the assessment was not available on the MAR. Continued review of the MAR and the corresponding progress notes failed to show any PRN treatment was provided. However, review of a pain monitoring schedule summary provided by the DON showed the pain assessment was documented at 6:22 PM on 8/10/15. The DON then provided a medication administration summary which showed the resident was given a scheduled acetaminophen tablet at 8:50 PM that evening. Interview with the DON on 8/12/15 at 5:55 PM verified the time frame between when the resident was assessed for pain and when the medication was administered should have been within the hour. 3. Review of the August 2015 MARs showed resident # 103 was assessed as having a pain level of a 3 out of 10 on both 8/10/15 and 8/11/15 in the evening. Continued review of the MAR showed orders for Narco tablet 5-325 mg	{F 309}	**Identification of Other Residents Potentially Affected:** All residents have the potential to be affected. An audit was completed to identify any residents who were not being assessed routinely for pain, having pain medication administered for stated pain, and timeliness of re-evaluation of the efficacy of pain medications. **Systemic Changes:** All residents have had routine pain assessments entered into the PCC electronic medical record system, and are reflective in the resident's EMAR. The Licensed Nurses were educated on Pain Assessments and Pain Medication Administration policies and practices by the Director of Nursing. The Unit Managers were educated on the daily monitoring of Pain Assessment and Pain Medication Administration for their assigned resident population. Any identified concern will be immediately addressed by the Unit Manager and reported to the Director of Nursing for further evaluation. **Monitoring:** Daily pain assessments and medication administration practices will be audited by the Unit Manager/designee x 90 days, and then weekly thereafter until such time as the QAPI Committee determines compliance has been met.	

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{F 309}	Continued From page 2 (Hydrocodone-Acetaminophen) take 1 tablet by mouth every 4 hours as needed for pain; and Tylenol tablet (Acetaminophen) take 500 mg by mouth every 4 hours as needed for pain. However, neither of the above listed pain medications were shown to be administered on either 8/10 or 8/11. Interview with the DON on 8/12/15 at 4:30 PM verified no treatment for these pain assessments was documented and no other type of pain medication was documented as having been administered for the resident. 4. Review of the July and August 2015 MARs showed resident #100 was admitted on 7/24/15 and was administered PRN pain medication on the following dates: 7/24, 7/27, 7/29, 7/30, 8/4, 8/8, 8/9, 8/10, and 8/11. The resident's pain rating for these dates ranged from 5-8 out of 10. Continued review of the MARs failed to show the resident was routinely assessed for pain. Interview with the DON on 8/12/15 at 4:30 PM verified all residents were expected to be assessed for pain on each shift daily. She verified the shift pain assessments for this resident was lacking, and may have been missed on the admission orders therefore not showing up on the MARs for the nurses to ensure monitoring.	{F 309}	Identified concerns will be immediately addressed and reported to the Director of Nursing for further evaluation, and reported to the QAPI Committee monthly for further analysis and recommendations.	
{F 367} SS=E	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, and review of education materials, the facility failed to ensure	{F 367}		

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(F 367)	Continued From page 3 the modified diet texture was an appropriate consistency for 1 of 2 meals observed (the noon meal). The findings were: In response to deficient practice cited on the 6/4/15 survey related to modified diet textures, an education inservice was provided. Review of the educational inservice materials presented to the dietary staff on 7/3/15 showed the purpose of a pureed diet is "...to provide foods that can be successfully and safely swallowed...the foods are easy to swallow because they are blended, whipped, or mashed until they are a 'pudding-like texture'...All foods on this diet should be smooth and free of lumps." Observation of the noon meal on 8/12/15 at 12:15 PM showed the mixed vegetables for the pureed diets was not an acceptable consistency. Interview with server #1 at that time revealed she did not think the texture was smooth enough. There were small pieces of carrots and broccoli, the mixture was not smooth. However, the server stated there were 4 residents with pureed diets in the dining room which was being served, and 2 of these residents had been served the pureed vegetables. Interview with the registered dietitian at 12:17 PM verified the vegetables needed to be further processed and did not meet the consistency requirements for a pureed diet. She further blended the vegetables at that time.	(F 367)	F367: Therapeutic Diet Prescribed by Physician **Corrective Actions:** Residents ordered to receive modified diet textures are being served the appropriate diet texture consistency for safe consumption. **Others Potentially Affected:** All residents who are ordered to receive a modified diet texture have the potential to be affected by this practice. **Systemic Changes:** The Registered Dietician re-educated the dietary staff on Puree/Mechanical Soft Diet Textures on 08/18/2015. Any newly hired dietary staff will receive the education on Puree/Mechanical Soft Diet Textures prior to working in the department. **Monitoring:** Daily diet texture audits will be performed by the RD/designee x 2 weeks, and then weekly x 90 days, until the QAPI Committee has determined that compliance has been met. Any concerns identified during the audits will receive immediate remediation, and will be reported to the QAPI Committee for further analysis and recommendations.	09/03/15