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

PRINTED: 01/04/2016
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 12/17/2015

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 A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 12/14/15 through 12/17/15. The survey was prompted by complaint intakes WY00002095, WY00002111, WY00002151, and WY00002155. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction is prepared as required by regulation. To remain in compliance with all Federal and State regulations, the facility has taken or will take the actions set forth in the following plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	F225 Investigate/Report Allegations/Individuals Corrective Actions: The allegation of abuse for resident #1 was reported to the State survey agency on 1/11/2016. Others Potentially Affected: All interviewable residents will be interviewed to determine whether there are any unidentified allegations of abuse.	2/1/2016

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

NHA 1-14-2016

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. Message left for Michael Spidell, NHA on 1/15/16 @ 3:45pm. Janelle Cox, RN/C

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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, review of facility policy and procedure, and review of State survey agency logs, the facility failed to report an allegation of abuse to the State survey agency for 1 of 4 allegations (resident #1) reviewed. The findings were: Interview with resident #1 on 12/14/15 at 4:15 PM revealed an allegation of physical abuse. The resident stated s/he was thrown onto his/her bed by someone, which caused the resident to hit the wall. The resident said the person also pulled him/her off the bed onto the floor in his/her room during the incident. The resident was unable to name the responsible party. However, the	F 225	**Systemic Changes:** All staff will be re-educated on reporting allegations of abuse, what constitutes abuse, the timing of required reporting, and who should be notified of allegations of abuse, on 1/25/2016. The facility will develop a process for reporting, including primary reporter and back-up reporting responsibility. Allegations of abuse will be reported at the daily Quality Council Meeting by the attending members, with follow up assigned to specific individuals. **Monitoring:** Weekly audit of all allegations of abuse will be completed x one month and then monthly until the QAPI Committee has determined compliance has been met.	

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F 225	Continued From page 2 resident repeated the allegation and stated it happened 2 days prior. The resident appeared anxious and upset while describing the incident. The resident lived on the secured unit and was cognitively impaired. The allegation of abuse was reported to RN #1 on 12/14/15 at 4:30 PM after the interview with the resident. Review of State agency incident report logs on 12/17/15 at 10:30 AM showed no report of the abuse allegation was made to the agency. Review of the facility's policy entitled, "Abuse Prevention Plan," last revised October 2014 showed "The Administrator is ultimately in charge of the Abuse Prohibition plan and must be informed of all alleged or substantiated incidents of abuse, neglect, or maltreatment immediately/no less than 24 hours...The State Agency must also be notified immediately." Interview with the DON on 12/17/15 at 12:05 PM confirmed the allegation of abuse was not reported to the State agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF 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, staff interview and policy and procedure review, the facility failed to maintain resident dignity for 2 of 4 sample	F 241	F241 Dignity and Respect of Individuality Corrective Actions Residents #9 and #18 have their Foley drainage bags covered with a privacy bag, when in a public setting. Others Potentially Affected Residents who have a Foley catheter have the potential to be affected. An audit was completed for all residents who have a Foley catheter to ensure that privacy bags were in use when the resident is out of their room and in a public setting.	2/1/2016

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F 241	Continued From page 3 residents (#6, #18) with indwelling urinary catheters. The findings were: 1. Observation of resident #6 on 12/16/15 at 12 PM showed the resident was seated in a wheelchair in the main dining room. A urine drainage bag, containing urine, was hanging from the bottom of the wheelchair. The bag was hanging next to, but was not concealed in, a bag holder. 2. Observation of resident #18 on 12/16/15 at 12 PM showed the resident was seated in a wheelchair in the facility dining room. A urine drainage bag, containing urine, was hanging from the bottom of the wheelchair exposed to view. 3. Review of the facility's policy entitled, "Catheter (Urinary Drainage) Bag Holder," last revised April 2003 showed the policy "Restores the dignity of catheterized residents by concealing urinary drainage bags from public view." Further review of the policy showed "All catheter bags must be placed in a drainage bag holder when the resident is in a wheelchair, recliner, Gari-chair, or up ambulating to restore the dignity of the resident..." 4. Interview with the DON on 12/17/15 at 3:20 PM confirmed catheter drainage bags are to be covered to provide the residents dignity.	F 241	**Systematic Changes** All staff will be educated on the need for maintaining privacy for residents who have a Foley catheter by keeping the drainage bag in a privacy bag when out of the resident's room, on 1/25/2016. **Monitoring** An audit will be completed on Foley Drainage privacy coverings, 3x a week for thirty days, and then weekly for 90 days, or until the QAPI Committee determines compliance has been met.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	**F253 Housekeeping and Maintenance Services** **Corrective Actions** The door frame located in the 200 unit shower room was repaired on 1/04/2016.	2/1/2016

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F 253	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 3 of 4 resident units (200, 300, 500). The findings were: 1. Observation on 12/17/15 at 8:40 PM showed a door frame located in the 200 unit shower room was damaged which exposed the underlying metal. The damaged area measured 43 inches up from the floor, and was uncleaneable. Further, there was a broken tile on the base of the wall that separated the shower and tub area. The broken tile exposed an area that measured 12 inches by 5 1/2 inches that was uncleanable. 2. Observation on 12/17/15 at 8:47 AM showed a handrail had been removed outside of the bathroom on the 200 unit and the wall paper was coming loose, exposing the underlying drywall. 3. Observation on 12/17/15 at 8:45 AM showed a door frame located in the 300 unit shower room was damaged, which exposed the underlying metal. The damaged area measured 33 inches up from the floor, and was uncleanable. Further, there were 2 missing tiles on the base of the wall that separated the shower and tub area. The missing tiles exposed an area that measured 4 inches by 2 inches and was uncleanable. 4. Observation on 12/17/15 at 9 AM showed the 500 unit had a tear in the carpet, that measured 7 inches by 1/2 inch, at the doorway which separated the east wing and the dining area. Further, the carpet in the dining area near the activity room had a tear that measured 6 1/2	F 253	The 200 unit shower base of wall tile between the shower and tub was repaired on 1/31/2016. The wall outside of the bathroom on the 200 unit has been repaired on 1/04/2016. The door frame on the 300 unit shower room was repaired on 1/04/2016. The 300 unit shower room base of wall two missing tiles were replaced on 1/31/2016. The carpet in the 500 unit near the east wing and dining room doorway will be repair or replaced by 1/31/2016. The carpet in the 500 unit dining area near the activity room will be repaired or replaced by 1/31/2016. Others Potentially Affected All residents have the potential to be affected by this practice. A visual audit of all carpeted areas within the facility and all bathing areas will be conducted by 1/31/2016 to determine whether other areas need to be repaired. Systematic Changes The Maintenance Department will be educated on inclusion of visual audits of bathing area tiles, door frames, and carpeting in the routine preventive maintenance program by 1/31/2016.	

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F 253	Continued From page 5 inches by 3 inches. Both areas exposed the underlying padding, were uncleanable, and created a tripping hazard. 5. Interview with the Maintenance Director on 12/17/15 at 2 PM revealed the facility was not aware of the areas, confirmed the areas were uncleanable, and confirmed the carpet was a safety concern.	F 253	Shower room tiles, door frames, and carpeting will be added to the Preventative Maintenance Program. Monitoring A weekly visual audit will be completed on carpeting, shower room tiles, and door frames x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure	F 280	F280 Right to Participate Planning Care-Revise CP Corrective Actions Resident #18's care plan will be updated to reflect the resident's current needs related to the use of the left foot boot. Resident #43's care plan will be updated to reflect the resident's current needs related to the use of Prevalon boot(s). Others Potentially Affected All residents who use specialty equipment or assistive devices have the potential to be affected by this practice. An audit will be completed on all residents who utilize specialty equipment or assistive devices to determine others potentially affected. Systematic Changes The Nursing Department will be educated on resident use of specialty equipment or assistive devices, the process for care plan implementation within the electronic medical record, and verification that equipment/devices are utilized per resident care plan.	2/1/2016

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F 280	Continued From page 6 the care plan was updated to reflect current resident needs for 2 of 14 sample residents (#18, #43). The findings were: 1. Review of the 10/6/15 significant change MDS assessment showed resident #43 had diagnoses that included a pressure ulcer of the heel. Review of progress notes showed the resident had falls on 7/20/15 and 8/10/15 that were attributed to the resident attempting to self-transfer while wearing Prevalon (padded) boots on both feet. Review of the resident's care plan for fall prevention showed an intervention was initiated on 7/21/15 for the resident to have "Prevalon boot to Left foot, Non-slip sole shoe to right foot when up in wheelchair." The following concerns were identified: a. Observation of the resident on 12/14/15 at 2:12 PM showed the resident was seated in a wheelchair in his/her room with Prevalon boots on both feet. b. Observation of the resident on 12/16/15 at 12 PM and 5 PM showed the resident was seated in a wheelchair with Prevalon boots on both feet. c. Observation of the resident on 12/17/15 at 11:55 AM showed the resident was seated in a wheelchair with Prevalon boots on both feet. d. Interview with the DON on 12/17/15 at 2:40 PM revealed the resident no longer attempted to self-transfer, and wore Prevalon boots on both feet due to pressure ulcer risk. The DON further confirmed the resident's care plan should have been updated. 2. Review of the 11/9/15 admission MDS assessment showed resident #18 had diagnoses that included "other fracture." Review of the resident's care plan for a fracture of the left fibula, last revised on 11/18/15, showed the resident had	F 280	Monitoring A weekly audit on all Nursing Units will be performed related to resident use of specialty equipment or assistive devices and related care plan development/update. The audit results will be reported to the QAPI Committee by the DNS/designee for further analysis and recommendation. Audits will be completed weekly x 90 days or until such time that the QAPI Committee has determined that compliance has been met.	

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F 280	Continued From page 7 "...a boot that is on [his/her] left foot and is to be worn at all times..." and was "...weight bearing on [his/her] left foot with boot." The following concerns were identified: a. Observation of the resident on 12/16/15 at 12 PM showed the resident was seated in a wheelchair in the dining room. The resident was not wearing a boot. b. Observation of the resident on 12/17/15 at 12:05 PM showed the resident was seated in a wheelchair in the dining room. The resident was not wearing a boot. c. Interview with the DON on 12/17/15 at 2:40 PM revealed the resident only wore the walking boot when receiving physical therapy. The DON further confirmed the resident's care plan should have been updated to reflect the current usage of the boot.	F 280		
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 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 as developed for 2 of 14 sample residents (#25, #49). The findings were: 1. Review of the 9/3/15 skin care plan showed resident #25 was at risk for skin breakdown related to incontinence and the need for	F 282	F282 Services by Qualified Persons/Per Care Plan Corrective Actions Resident # 25's wheelchair received a pressure redistribution cushion on 12/20/2015, and is used per the resident's care plan. Resident #49 is offered the opportunity to reposition or toilet, per the resident's care plan. Others Potentially Affected Residents at risk for skin breakdown have the potential to be affected by this practice. An audit will be performed on all residents at risk for skin breakdown, to determine the resident is receiving care per the resident's care plan.	2/1/2016

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F 282	Continued From page 8 extensive assistance with bed mobility. The care plan showed the resident used a pressure redistribution mattress on the bed and cushion in the wheelchair. The following concerns were identified: a. Observation of the resident on 12/14/15 from 2:20 PM to 5:30 PM showed the resident was up in the wheelchair with no cushion. b. On 12/17/15 at 2:45 PM the resident was observed up in the wheelchair without any cushion. At that time LPN #1 verified there was not currently a cushion in the seat, and she was unable to find one. 2. Review of the quarterly MDS assessment dated 11/16/15 showed resident #49 had diagnoses that included Alzheimer's disease, depression, and other persistent mental condition. Continued review showed the resident required extensive physical assistance of 2 or more persons for bed mobility and transfers, and was at risk for skin breakdown. Review of the care plan for skin breakdown revised on 8/3/15 showed the resident was at risk for skin breakdown related to cognitive impairment and poor nutrition. Further, the interventions included to reposition the resident every hour when up and every two hours while in bed. The following concerns were identified: a. Continuous observation on 12/15/15 from 9:20 AM to 11:50 AM showed the resident was in his/her recliner and was not offered assistance to reposition or use the bathroom. b. Interview with the Director of Nursing on 12/17/15 at 3:20 PM revealed the residents should be repositioned per their care plans.	F 282	Systematic Changes The Nursing Department will be educated on resident care for those considered at risk for skin breakdown and following the resident's care plan, by 1/25/2016. Monitoring Audits will be completed 3x week on all nursing units, to ensure that residents at risk for skin breakdown have wheel chair cushions in use and are offered to reposition or toilet, per resident care plan; 3x week for 90 days or until the QAPI Committee has determined compliance has been met.	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	F314 Treatment/Svcs to Prevent/Heal Pressure Sores	2/1/2016

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F 314	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure measures were implemented to prevent development of pressure sores for 3 of 7 sample residents (#25, #39, #49) and 1 non-sample resident (#20) who were at risk for skin breakdown. The findings were: 1. Review of the quarterly MDS assessment dated 11/16/15 showed resident #39 had diagnoses that included other mental disorders due to known physiological condition, dorsalgia (pain in the upper back), and urgency of urination. Continued review showed the resident required limited assistance of 1 person for transfers and toilet use, and was at risk for skin breakdown. Further, the resident was marked as having a pressure-reducing device for the chair. Review of the care plan for skin breakdown revised on 9/22/15 showed the resident was at risk for skin breakdown related to limited mobility, edema in lower extremities, and occasional urinary incontinence. The following concerns were identified: a. Continuous observation on 12/15/15 from	F 314	Corrective Actions Resident #39 is repositioned and/or being toileted per the individualized plan of care. Resident #25 uses a pressure redistribution cushion in his wheelchair, per the individualized plan of care. Resident #49 is repositioned and/or toileted per the individualized plan of care. Resident #20 uses a pressure redistribution cushion in her wheelchair, per the individualized plan of care. Others Potentially Affected An audit of all residents will be completed to determine those who are considered at risk for skin breakdown. Any resident determined to be at risk for skin breakdown has the potential to be affected by this practice. Systematic Changes The Nursing Department will be educated on risk for skin breakdown and prevention of pressure ulcers by the DNS, by 2/1/2016. All residents determined to be at risk for skin breakdown will utilize a pressure redistribution device in bed and wheelchair. Care plans will be reviewed and updated to reflect individualized needs.	

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GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 314	Continued From page 10 9:15 AM to 11:57 AM showed the resident was in his/her bed and was not offered assistance to reposition or use the bathroom. b. Observation on 12/15/15 at 11:57 AM showed CNA #1 and a student entered the room and woke the resident up for the lunch meal. The resident stood and transferred to the wheelchair with stand-by assistance from the staff member. The resident was then taken to the dining room without being checked for incontinence or offered toileting. Further, no pressure-relieving device was in the resident's chair. Continuous observation showed after the meal at 1:32 PM CNA #2 assisted the resident back to his/her room and assisted him/her to use the bathroom. The resident grabbed the assist bar and stood while the CNA removed the resident's brief. Interview with the CNA at that time confirmed the resident's brief was wet with urine. 2. Review of the 9/3/15 skin care plan showed resident #25 was at risk for skin breakdown related to incontinence and need for extensive assistance with bed mobility. The focus area of the care plan showed the resident used a pressure-redistribution mattress on the bed and cushion in the wheelchair. The following concerns were identified: a. Observation of the resident on 12/14/15 from 2:20 PM to 5:30 PM showed the resident was up in the wheelchair with no cushion. b. On 12/17/15 at 2:45 PM the resident was observed up in the wheelchair without any cushion. At that time LPN #1 verified there was not currently a cushion in the seat, and she was unable to find one at that time. 3. Review of the quarterly MDS assessment dated 11/16/15 showed resident #49 had	F 314	Monitoring The DNS or designee will perform an audit on all residents at risk for skin breakdown, weekly on all units. The DNS will report findings from the audit to the QAPI Committee, for further analysis and recommendations; until such time that the QAPI Committee determines that compliance has been met.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2089 LARAMIE STREET TORRINGTON, WY 82240

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F 314	Continued From page 11	F 314		

diagnoses that included Alzheimer's disease, depression, and other persistent mental condition. In addition, the resident required extensive physical assistance of 2 or more persons for bed mobility and transfers, and was at risk for skin breakdown. Review of the care plan for skin breakdown revised on 8/3/15 showed the resident was at risk for skin breakdown related to cognitive impairment and poor nutrition. Further, the interventions included to reposition the resident every hour when up and every two hours while in bed. The following concerns were identified:

a. Continuous observation on 12/15/15 from 9:20 AM to 11:50 AM showed the resident was in his/her recliner and was not offered assistance to reposition or use the bathroom. The resident was then assisted into the wheelchair and taken to the dining room.

b. The resident was not offered toileting until 12:45 PM.

c. Interview with the DON on 12/17/15 at 3:20 PM revealed residents should be toileted before and after meals, at bedtime, and as needed, and residents should be repositioned as specified by their care plans.

4. Review of the 12/1/15 physical therapy evaluation showed resident #20 was status post fall with right hip fracture. The evaluation showed the fall with fracture occurred on 11/22/15 and the resident was unable to transfer, walk or perform self-cares. A therapy plan was developed. Review of the 11/25/15 "Braden Scale for Predicting Pressure Sore Risk" showed the resident was at high risk for developing pressure sores. The following concerns were identified:

a. Observation on 12/16/15 at 4 PM showed the resident was seated in a wheelchair and there

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F 314	Continued From page 12 was no cushion/pressure-reducing device. Interview with LPN #1 at 4:20 PM revealed the resident had started using the wheelchair after the hip fracture and she was unaware of any cushion used for the resident while up in the wheelchair. b. Review of the care plan showed on 12/1/15 there was an update to include the fall with fracture. The interventions included increased help with transfers and use of a wheelchair for locomotion. However, the care plan failed to address the resident's increased risk for pressure ulcers and the possible need for a pressure-reducing device while in the wheelchair.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure services were provided to promote normal bladder function for 1 of 7 sample residents (#39) with urinary incontinence. The findings were:	F 315	F315 No Catheter, Prevent UTI, Restore Bladder Corrective Actions Resident #39 is being toileted per the individualized plan of care. Others Potentially Affected An audit of all residents will be completed to determine those who are considered at risk for incontinence. Residents who require assistance with toileting and/or incontinence care are at risk for being affected by this practice. Systematic Changes The Nursing Department will be educated on the risk for incontinence and the need for individualized plans of care for toileting and/or incontinence care. All residents determined to be at risk for incontinence or requiring assistance with toileting will have an individualized plan of care reviewed and updated.	2/1/2016

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F 315	Continued From page 13 1. Review of the quarterly MDS assessment dated 11/16/15 showed resident #39 had diagnoses that included other mental disorders due to known physiological condition, dorsalgia (pain in the upper back), and urgency of urination. Continued review showed the resident required limited assistance of 1 person for transfers and toilet use, and was frequently incontinent of urine. Review of the care plan for skin breakdown, revised on 9/22/15, showed the resident was at risk for skin breakdown related to limited mobility, edema in lower extremities, and occasional urinary incontinence. The following concerns were identified: a. Continuous observation on 12/15/15 from 9:15 AM to 11:57 AM showed the resident was in his/her bed and was not offered assistance to use the toilet. b. Observation on 12/15/15 at 11:57 AM showed CNA #1 and a student entered the room and woke the resident up for the lunch meal. The resident stood and transferred to the wheelchair with stand-by assistance from the staff member. The resident was then taken to the dining room without being checked for incontinence or offered toileting. c. Observation on 12/15/15 at 1:32 PM showed the resident was sitting in the common area in his/her wheelchair. CNA #2 assisted the resident back to his/her room and assisted him/her to use the bathroom. The resident grabbed the assist bar and stood while the CNA removed the resident's brief. Interview with the CNA at that time confirmed the resident's brief was wet with urine. 2. Interview with the DON on 12/17/15 at 3:20 PM revealed residents should be toileted before meals, after meals, at bedtime, and as needed.	F 315	Monitoring A weekly audit will be completed by the DNS/designee, on all residents determined to require assistance with toileting or incontinence care. The DNS will report the audit findings to the QAPI Committee for further analysis and recommendations, until such time as the QAPI Committee has determined that compliance has been met.	

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F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure range of motion (ROM) services were provided as planned for 1 of 1 sample residents (#39) and 3 non-sample residents (#4, #9, #73) with restorative nursing needs. The findings were: 1. Review of the 12/18/15 quarterly MDS assessment showed resident #4 had bilateral lower extremity ROM limitations. Review of the December 2015 nursing rehabilitation (rehab) notes showed a restorative nursing program to maintain strength for upper and lower extremities 3 times weekly at 15 minute intervals was planned. The notes showed the resident refused on 12/9/15 and completed the training on 12/10/15. There were no other days during the month when the services were provided, or refused. 2. Review of the December 2015 nursing rehab notes showed the plan for resident #39 was to ambulate with a front-wheeled walker 150 to 200 feet 3 times weekly. The notes showed the training was completed on 12/2/15 and refused by the resident on 12/4/15. Three other dates	F 318	F318 Increase/Prevent Decrease in Range of Motion Corrective Actions Residents #39, #4, #9, and #73 are receiving Restorative Nursing per the individualized plan of care. Others Potentially Affected An audit will be performed on all residents receiving Restorative Nursing to determine others potentially affected. All residents who are receiving Restorative Nursing have the potential to be affected by this practice. Systematic Changes All Staff will be educated on the needs of Restorative Nursing to prevent decline or improve range of motion, by 2/1/2016. Restorative aides and CNA's will be educated on the assignments of restorative duties to ensure that all residents receive Restorative Nursing per their individualized plan of care. A weekly review of the nursing staff schedule will be reviewed to assure the Restorative Aides are not working floor assignments. A weekly meeting will be conducted with the Restorative RN Director and aides to assure residents are receiving therapies per their plan of care.	2/1/2016

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F 316	Continued From page 15 recorded: 12/6/15, 12/9/15, and 12/14/15. All of which showed only "not applicable." 3. Review of the 12/16/15 quarterly MDS assessment showed resident #73 had bilateral lower extremity ROM limitations. Review of the December 2015 nursing rehab notes showed the plan for the resident was to use pulleys 3 times weekly for 10 minute intervals, and to complete elbow/extension with resistance 3 times weekly, 10-15 repetitions per joint. The notes showed the training was completed each time it was offered which was 3 days during the month on 12/4/15, 12/7/15, and 12/9/15. As of review on 12/17/15 the training should have been offered at least 7 times. 4. Review of the 11/26/15 quarterly MDS assessment showed resident #9 had bilateral upper and lower ROM limitations. Review of the December 2015 nursing rehab notes showed the plan for the resident was to ambulate 100-200 feet with a front-wheeled walker 3 times per week. The notes showed the training was completed on 12/7/15 and 12/9/15. The training was refused by the resident on 12/4/15, and was shown as "not applicable" on 12/1/15, 12/3/15, 12/12/15, 12/13/15, and 12/16/15. 5. Interview with the DON on 12/17/15 at 12:05 PM verified the dates which showed "not applicable" were dates when the program was planned, but not offered. The DON stated the programs were unable to be implemented as planned due to a shortage of CNAs working since approximately mid-November 2015.	F 316	Monitoring The DNS/designee will perform a weekly audit on all residents who are receiving Restorative Nursing, to determine whether residents are receiving Restorative care as recommended. The DNS will report audit findings to the QAPI Committee for further analysis and recommendations, until such time as the QAPI Committee determines that compliance has been met.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353	F353 Sufficient 24-Hr Nursing Staff Per Care Plans	2/1/2016

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F 353	Continued From page 16 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of the daily staff posting sheets, the facility failed to ensure adequate staff were assigned to provide resident care in accordance with resident care plans 4 of 4 units. The census was 64. The findings were: 1. Interview with the administrator on 12/14/15 at 10:50 AM verified he was aware of nurse staffing needs and they were working to address the shortage of CNAs available to fill shifts. Additional interview with the administrator on 12/17/15 at 3:35 PM revealed 4 CNAs transferred recently to	F 353	**Corrective Actions** The facility documents nursing hours, nursing assistants hours and census hours daily per policy. **Others Potentially Affected** All residents have the potential to be affected by this practice. **Systematic Changes** A daily visual audit with the Staff Scheduler will be conducted to assure sufficient staff are scheduled to deliver care to the residents. Open positions are posted on the facility web site and interviews are being conducted for applicants. **Monitoring** The DNS/ designee will perform a weekly audit on staffing needs to determine the correct nursing staff to resident ratio is appropriate. The DNS will report audit findings to the QAPI Committee for further analysis and recommendations until such time as the QAPI Committee determines that compliance has been met.	

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F 353	Continued From page 17 other company buildings. He stated there were many students going through the CNA training program which used the facility as a clinical training site and some of these were expected to be employed by the facility upon completion of their course. In addition, the facility was also implementing a plan to have non-nursing staff assist with resident needs which did not require a CNA, such as taking them to the dining room. 2. Interview with the DON on 12/17/15 at 3:20 PM revealed the facility's minimum staffing was 6 CNAs for day shift, 5 CNAs for night shift, 4 nurses for day shift, and 4 nurses for night shift. Further, the facility had 7 open CNA positions and 2 open nurse positions. 3. Review of the daily staff posting sheets from 11/17/15 to 12/16/15 showed the facility had fewer than 6 CNAs on day shift on 6 out of 30 days, fewer than 4 nurses on day shift 17 out of 30 days, and less than 4 nurses on night shift 28 out of 30 days. These numbers were determined by taking the actual hours worked by each category of nursing staff, and then divided by the hours per shift (12). 4. Interview with a group of 8 residents on 12/15/15 revealed the facility needed more staff to complete bathing, toileting, and medication administration. One resident stated on more than one occasion s/he had been incontinent of bowel due to inadequate numbers of staff to answer his/her call light timely. Two residents reported a frequent nurse shortage on their units in the evenings which resulted in medications being administered as late as 9 or 10 PM. Two residents revealed the bathing/shower schedules were seldom kept; they had to wait and receive	F 353		

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F 353	Continued From page 18 showers on days when staff were available to give them. One of these residents reported a preference for a tub bath which was denied because there were not enough staff who knew how to work the tub. 5. Interview with the DON on 12/17/15 at 12:05 PM revealed the facility's restorative nursing program was not implemented as planned due to a shortage of CNAs working since approximately mid-November 2015.	F 353		
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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure acceptable hand hygiene techniques were utilized, and that food service equipment was maintained in a sanitary condition in 1 of 2 food service areas (the main dining room kitchen). The findings were: 1. Observation in the main dining room kitchen on 12/16/15 from 11:40 AM to 12:25 PM showed dietary staff #1, #2, and #3 used disposable gloves while working with resident food and clean	F 371	F371 Food Procure, Store/Prepare/Serve – Sanitary Corrective Actions The facility provides acceptable hand hygiene techniques within the Dietary Department and maintain equipment in a sanitary condition. The white cutting board was discarded, and replace with new equipment. Others Potentially Affected An audit will be performed on all cutting boards to ensure that only cleanable surface cutting boards are used within the dietary department. An audit will be performed on all Dietary employees for acceptable hand hygiene and glove use. All residents have the potential to be affected by these practices.	2/1/2016

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F 371	Continued From page 19 equipment. During the observation period all 3 staff members were observed to handle dirty equipment with their gloved hands and proceed to work with resident food and/or clean equipment without performing hand hygiene. The dirty equipment which contaminated the gloves included refrigerator handles and utensil drawers. In addition, staff member #2 left the kitchen to retrieve items from the 500 unit. Upon returning to the kitchen, this staff member failed to perform any hand washing prior to putting on a set of disposable gloves. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands 2. Observation in the main dining room kitchen on 12/16/15 at 11:40 AM showed there was a white cutting board stored on a clean equipment rack. The cutting board was visibly scored and discolored. In addition, the white cutting board surface of the steam table was visibly scored and discolored. According to Food Code 2013, U.S. Public Health Service: 4-201.11 "EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions. 3. Interview with the registered dietitian and the administrator on 12/16/15 at 12:40 PM verified the staff had not performed proper hand washing, and the cutting boards were in need of resurfacing to ensure they could be effectively	F 371	Systematic Changes The Dietary Department will be educated by the Registered Dietician on hand hygiene, glove use, and the requirement for cleanable surfaces in the dietary department. Cutting boards will be checked for stains or cuts/gouges during the routine cleaning schedule. Monitoring The Registered Dietician or designee will audit hand hygiene, glove use, and cutting board surfaces 3x weekly for 30 days, and then weekly until such time as the QAPI Committee has determined that compliance has been met. Audit findings will be reported to the QAPI Committee for further analysis and recommendations.	

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F 371	Continued From page 20 cleaned and sanitized.	F 371		
F 425 88=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to ensure medications were available and administered for 1 non sample resident (#40). The findings were: 1. Interview with resident #40 on 12/16/15 at 4:12 PM revealed his/her Tramadol (pain medication) was not available and s/he had been without for multiple days.	F 425	F425 Pharmaceutical Svc – Accurate Procedures, RPH **Corrective Actions** Resident #40 is receiving medications per physician's orders. The Tramadol was delivered on 12/16/15, and continues to be administered as ordered. **Others Potentially Affected** An audit will be completed matching the physician's orders, the med cart, and the chart to ensure that all medications ordered by a physician are available to be administered. All residents have the potential to be affected by this practice. **Systematic Changes** The Licensed Nurses will be educated on the procedure for ordering medications, receiving medications, and the process to follow if a medications cannot be located. The facility will develop a checklist for the licensed nurses to follow when ordering and receiving medications.	2/1/2016

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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 12/17/2015

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 428	Continued From page 21 2. Review of the December 2015 medication administration record showed the resident had an order to receive Tramadol 50 mg (milligrams) 1/2 tablet by mouth at bedtime and Tramadol 50 mg 2 tablets by mouth every 6 hours as needed (PRN). The PRN Tramadol was administered 2 to 4 times daily between 12/1/15 and 12/13/15 and there was no evidence of administration after 12/13/15. Further, documentation of the scheduled dose showed the medication was "not available" on 12/14/15 and 12/15/15. 3. Interview with RN #2 on 1217/15 at 3:05 PM revealed the medication was delivered to the facility on the night shift of 12/16/15. 4. Interview with the DON on 12/17/15 at 3:20 PM revealed resident medications should not be unavailable, the nurses were expected to call the pharmacy if they were out of a medication.	F 428	Monitoring The DNS/designee will audit each resident's MAR/associated med cart weekly to determine whether any medication was not available for administration. Audit reports will be submitted to the QAPI Committee for further analysis and recommendations, until such time as the QAPI Committee has determined that compliance has been met.	