RECEIVED
WY Dept of He
JAN 14 2016
Healthcare Licensing and Surveys

PRINTED: 12/29/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/15/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system that communicates with the Alzheimer building (SCU). The facility had a capacity of 75 certified Medicaid beds with a census of 57.	K 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.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hazardous areas were protected from the corridor with self-closing doors in 1 of 6 smoke compartments. The findings	K 029	K029 Life Safety Code Standard Corrective Actions: All combustible materials were removed from room #214. Others Potentially Affected: All the Residents on the 200 unit have the potential to be affected by this practice. A visual audit of all facility storage area doors will be conducted by the Maintenance Director or designee to determine the proper self-closing devices are installed and functioning. Systemic Changes: The Maintenance Department will be educated on hazardous areas and the requirements for self-closing devices on the doors of those storage areas.	2/1/2016

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

NHA 1-14-16

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 VIA Phone Call w. Th Administrator

Michael Speidel on 1/19/16 @ 12:54pm.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/15/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 were: Observation on 12/15/15 at 12:05 PM revealed Room #214 was being utilized for storage of combustible materials. Further observation revealed the door to the corridor was not provided with a self-closing device. At the time of the observation the Facility Maintenance Manager acknowledged the door was not self-closing. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	**Monitoring:** A weekly audit will be completed on all storage area doors x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 2 of 6 smoke compartments. The findings were: Observation on 12/15/15 from 11:40 AM to 12:10 PM revealed the door locks required tight pinching, and more than one releasing operation to make the door operable. Laundry hall door to kitchen, door from kitchen to dining room, and the clinical education office. At the time of the observations the Facility Maintenance Manager acknowledged the door locks required more than one operation.	K 038	**K038 NFPA Life Safety Code Standard** **Corrective Actions:** The locks on Laundry Hall Door to the Kitchen, the door from the kitchen to dining room, and the clinical education office were changed to single operation door locks. **Others Potentially Affected:** All residents have the potential to be affected by this practice. A Visual audit of locking systems on all facility doors will be conducted by the Maintenance Director or designee to ensure all doors have single operation locking devices installed per NFPA Life Safety Code Standard.	2/1/2016

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

PRINTED: 12/29/2015
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 01 - MAIN BUILDING 01 B. WING _____	12/15/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 2 Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	**Systemic Changes:** The Maintenance Department will be educated on the NFPA requirement that all door locks must be single operation in order to be deemed to be in compliance. All new door locks must be inspected by Maintenance Director or designee in order to ensure that they are single operation prior to installation. **Monitoring:** A weekly audit on door locks will be conducted by the Maintenance Director or designee x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee.	

RECEIVED
WY Dept of Health
JAN 14 2016
Healthcare Licensing and Surveys

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

PRINTED: 12/29/2015
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 02 - ALZHEIMERS BUILDING B. WING	12/15/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 2007. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch and an addressable fire alarm system that communicates with the nursing home building. The facility had a capacity of 28 certified Medicaid beds with a census of 26.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to arrange exit access so that exits are readily accessible at all times in 1 of 4 smoke compartments. The findings were: Observation on 12/15/15 from 1:10 PM to 1:20 PM revealed the door locks to the food storage, and both doors in the kitchen required tight pinching, and more than one releasing operation to make the door operable. At the time of the observations the Facility Maintenance Manager acknowledged the door locks required more than	K 038	**K038 NFPA Life Safety Code Standard** **Corrective Actions:** The locks on the food storage door and both doors in the kitchen were changed to single operation door locks. **Others Potentially Affected:** All residents have the potential to be affected by this practice. A Visual audit of locking systems on all facility doors will be conducted by the Maintenance Director or designee to ensure all doors have single operation locking devices installed per NFPA Life Safety Code Standard.	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 Via Phone Call with Administrator Michael Speidel on 1/19/16 @ 1254 pm

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

PRINTED: 12/29/2015
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 02 - ALZHEIMERS BUILDING B. WING _____	12/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 one operation. Ref: 2000 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.5.4	K 038	**Systemic Changes:** The Maintenance Department will be educated on the NFPA requirement that all door locks must be single operation in order to be deemed to be in compliance. All new door locks must be inspected by Maintenance Director or designee in order to ensure that they are single operation prior to installation. **Monitoring:** A weekly audit on door locks will be conducted by the Maintenance Director or designee x 30 days, then monthly x 90 days, until compliance has been determined to have been met by the QAPI Committee.	