PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN 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 _____	04/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	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 this 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 (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1998. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and with an addressable fire alarm system. The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 90 residents.	K 000		
K 029 SS=E	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 separated from use areas in 1 of 6 smoke compartments. The findings were:	K 029	Facility practice is that all equipment belts and related items will be stored in appropriate enclosed storage areas. Hoyer lift belts were removed by staff from corridor alcove on 4/13/2011. This will be monitored by monthly safety walkthroughs and reported to Safety committee monthly.	4/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Kozel — TITLE: NHA — (X6) DATE: 5/20/11

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.

FOC MODIFIED & APPROVED W/ NATALIE KOZEL, NHA ON 5/25/11.

RECEIVED
Wyoming Dept of Health
MAY 26 2011
Office of Healthcare Licensing and Surveys

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K 029	Continued From page 1 Observation of the corridor alcove near the RN assessment coordinator's office on 4/11/11 at 2:10 PM showed 15 Hoyer lift belts were stored on a four level steel rack. At the time of observation the assessment coordinator confirmed the belts were always stored in this location. She also reported that she was unaware storage areas could not be open to the corridor.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure sprinkler deficiencies observed by the sprinkler contractor were repaired during 4 of the past 4 quarters. The findings were: Review of the quarterly dry pipe sprinkler testing records conducted on 3/25/11, 12/09/11, 9/23/11 and 6/10/10 showed the contractor had made several comments about sprinkler deficiencies. The comments cited on each report read as follows: 1. The automatic air maintenance device needs to be installed. 2. The tamper switch is wired improperly and sets off the alarm and needs to be rewired or replaced. 3. Attic space above the administration hatch did not have adequate sprinkler coverage. 4. Alarm switch is faulty, piping appears to be	K 062	Contracted fire system inspection service will be scheduled to bring fire system issues back into compliance with NFPA regulations. This will be completed by contractor by 5/26/2011. This will be monitored by contracted fire system inspection service when they perform quarterly and annual inspections and will be reported to Safety committee quarterly.	~~7/12/11~~ 5/26/11

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K 062	Continued From page 2 obstructed, recommend replacement of the device and pipe. On 4/12/11 at 11:30 AM the maintenance director reported he was unaware of the contractor comments. Furthermore, he reported that he assumed the contractor would call him to schedule the needed work if devices needed repair or replacement. Observation of the attic space above the administration areas showed two sprinkler heads were more than 7 1/2 feet away from the barrier wall.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 6 smoke compartments. The findings were: Observation of resident room #401 on 4/12/11 at 8:43 AM showed the television set was plugged into an extension cord. At the time of observation the maintenance director reported he was aware extension cords were prohibited. Furthermore, he reported that the electrical devices were supposed to be inspected on a weekly basis by the housekeeping staff. He could not explain why the facility's inspection plan did not identify this prohibited wiring configuration.	K 147	Facility practice is that there is no use of extension cords throughout the facility according to NFPA regulations. Extension cord found in room 401 was removed by maintenance staff on 4/13/2011. This will be monitored by monthly safety walkthroughs and reported to Safety committee monthly.	~~7/12/11~~ 5/24/11

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	53A049	A. BUILDING 02 - ALZHEIMERS BUILDING B. WING _____	04/11/2011

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, New Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 2007. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 90 residents.	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ceilings were smoke resistant in 1 of 3 smoke compartments. The findings were: Observation of storeroom #549 on 4/12/11 at 10:23 AM showed three ceiling tiles had been removed. At the time of observation the maintenance director reported the tiles were removed because of an attic sprinkler repair in the area. He also reported the project had been completed more than a week before, and the contractor was supposed to have replaced all	K 012	Facility practice is that ceiling tile barrier shall remain intact according to NFPA regulations. Ceiling tiles were replaced by maintenance staff on 4/13/2011. Tiles will be monitored monthly by safety walkthrough monthly and reported to Safety committee quarterly.	~~7/12/11~~ 5/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Powell | TITLE: Administrator | (X6) DATE: 5/20/11

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
MAY 20 2011
Wyoming Dept of Health

POC approved w/ modifications w/ Natalie Powell, NHA
on 5/24/11.

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K 012	Continued From page 1 ceiling tiles.	K 012		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 2 smoke barrier walls was smoke resistant. The findings were: Observation of the south smoke barrier wall on 4/12/11 at 10:40 AM showed two unsealed pipe penetrations. The largest gap was a 1 inch circular penetration. At the time of observation the maintenance director reported he was aware of the smoke resistant requirement. He also reported the smoke barrier walls were only inspected on an annual basis.	K 025	Facility practice is that all smoke barriers will remain intact according to NFPA regulations. Unsealed penetrations were sealed with approved fire stop sealant by maintenance staff on 4/13/2011. These will be monitored annually and after contractor completes work by safety walkthrough and reported to Safety committee annually.	~~5/12/11~~ 5/20/11
K 038 SS=E	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	K 038	Tag K038 will start on Page 3	

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the corridor system had adequate headroom in 1 of 3 smoke compartments. The findings were: Observation of the south smoke barrier double doors on 4/12/11 at 9:19 AM showed the doors were equipped with a magnetic locking system. Further review showed the bottom of the magnetic lock did not have the required 6 feet 8 inch headroom. The bottom of the magnetic lock was only 6 feet 5 inches above the floor. At the time of observation the maintenance director reported he was not aware of the spacing requirement.	K 038	Required magnetic system for doors have been ordered and will be installed by electrical contractor to meet the required six foot eight inch clearance. We are requesting a time-limited waiver in order to receive the equipment and contractor will complete installation by August 1, 2011. These will be monitored by quarterly safety walkthrough and reported to Safety committee quarterly.	~~9/12/11~~ 5/29/11
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinklers were not obstructed in 2 of 3 smoke compartments. The findings were: 1. Observation of the Alzheimer's link on 4/12/11 at 9:16 AM showed the sprinkler near the south exit door was obstructed by the exit sign. The sprinkler was located 16 inches from the sign. At	K 062	Facility practice is that all ceiling mounted lights and exit signs will be installed within NFPA regulations. Electrical contractor moved the exit sign and the ceiling mounted light to comply with NFPA regulations on 5/12/2011. This will be monitored by contracted fire system inspection service when they perform quarterly and annual inspections and will be reported to Safety committee quarterly.	~~9/12/11~~ 5/29/11

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K 062	Continued From page 3 the time of observation the maintenance director reported he was aware of the spacing requirement. Furthermore, he reported the sprinkler system was inspected by an outside contractor on an annual basis, and the sprinkler gap had not been noted on the last report. 2. Observation of laundry room #557 on 4/12/11 on 10 AM showed the sprinkler was obstructed by a ceiling-mounted light. The sprinkler was located 2 inches from and 1 inch above the light fixture.	K 062	This page left blank intentionally	