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Healthcare Licensing and Surveys

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

PRINTED: 02/21/2017
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
	63A049	A. BUILDING _____ B. WING _____	C 01/12/2017

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 recertification survey was conducted by Healthcare Licensing and Surveys on 1/9/17 through 1/12/17. Complaint intakes WY00002304 and WY00002333 were also investigated in the course of the survey. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigations. The following common abbreviations are used throughout this document: ADL Activities of Daily Living CNA Certified Nurse Aide DON Director of Nursing LPN Licensed Practical Nurse MDS Minimum Data Set RD Registered Dietitian RN Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction does not constitute admission and/or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. 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 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 248	Corrective Actions: Resident 39 is being encouraged to participate in activities. Others Potentially Affected: All residents have the potential to be affected by this practice.	2/13/17

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

[signature] INHA 2-27-17 02/03/2017

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 - left message for Pat Ramirez, NHA on 3/1/17 @ 7:33am.

POC - 3/13/17

[signature]

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F 248	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview, and medical record review, the facility failed to encourage participation in activities for 1 of 10 sample residents (#39). The findings were: 1. Review of the 12/20/16 quarterly MDS assessment showed resident #39 had minimal depression, required the total assistance of 1 person for locomotion on and off the unit, and had diagnoses that included Parkinson's disease and rheumatoid arthritis. Review of the "Quality of Life" care plan last revised on 7/1/16 showed the resident needed assistance to and from activities, and had interventions which included to encourage the resident to participate in activities. The following concerns were identified: a. Observation on 1/10/17 at 9:16 AM showed the resident was in bed and did not participate in the activities during that morning. b. Observation on 1/12/17 at 8:55 AM showed an unidentified activity assistant was rounding in the dining room and asked residents if they would like to attend the morning activity "energize." Continued observation showed resident #39 was not asked to attend the activity. c. Interview with the resident's daughter on 1/9/17 at 4:30 PM revealed the facility had, in the past, taken the resident to activities and allowed him/her to watch. The resident appeared to enjoy watching the activities; however, the facility no longer did that. d. Interview with the activities director on 1/12/17 at 2:45 PM revealed the resident would gesture if s/he wanted to attend activities, and staff should offer the residents the opportunity to participate in activities.	F 248	**Systemic Changes:** The Activity Director has educated the Activity Department on inviting residents to attend activities and completing the resident participation logs to include if the resident accepted or declined to attend the activity when invited. **Monitoring:** Activity Director or Designee will audit four activity logs a week x four weeks and then monthly for two months for resident participation and acceptance and declination of activities. The Activity Director will report findings to the monthly QAPI Committee for further analysis and recommendations; until such time as the QAPI Committee has determined compliance has been sustained.	

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F 253	Continued From page 2	F 253	**Corrective Actions:**	2/13/17
F 253 SS=E	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 4 of 5 facility hallways (administrative, 300, 400, 500) were clean and in good repair. The findings were: 1. Observation on 1/11/17 at 5 PM showed the hallway floor outside laundry and maintenance had 84 tiles that measured 12 inches by 12 inches which were cracked, chipped, or broken, and created a surface that could not be cleaned effectively; 2. Observation on 1/11/17 at 5:03 PM showed the door of the 400 hallway shower room had a damaged area inside the room at the top of the door that measured 5 inches by 8 inches, where the finish had been removed and exposed the underlying wood, which created a surface that could not be cleaned effectively. 3. Observation on 1/11/17 at 5:08 PM showed the 300 hallway shower room floor had 2 tiles that measured 2 inches by 2 inches which were cracked, chipped, or broken, and created a surface that could not be cleaned effectively. 4. Observation on 1/11/17 at 5:17 PM showed the 500 hallway dining area had 2 blinds that were broken and did not function appropriately. 5. Interview with the maintenance assistance on	F 253	1. Bids to replace/repair the hallway floor tiles outside laundry and maintenance and the 300 shower room have been obtained. Flooring will be installed at contractor's first availability. 2. The 400 shower room door has been repaired. 3. The blinds in the 500 dining area have been repaired. **Others Potentially Affected:** All residents have the potential to be affected by this practice. A facility wide unit by unit audit will be completed by the Maintenance Director or Designee to identify floor tiles that need repaired, blinds that are broken, and doors that are damaged. **Systemic Changes:** The Maintenance Department will be educated on physical plant expectations. All staff will be educated on the work order process. **Monitoring:** The Maintenance Director or Designee will conduct weekly facility rounds to check to ensure: floor tiles are not chipped or broken, blinds are not broken, and doors are not damaged. Audits will be completed weekly for four weeks and monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/ discontinue audit.	

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F 253	Continued From page 3 1/12/17 at 10:45 AM confirmed the items needed to be fixed. Further, it was revealed the facility did not have a plan to correct any of the damaged areas.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI (resident assessment instrument) version 3.0 manual, the facility failed to ensure a significant change assessment was completed for 2 of 16 sample residents (#10, #39) with a significant change. The findings were: 1. Review of the medical record showed resident #39 was admitted to the facility on 8/1/14 with diagnoses which included Parkinson's Disease and rheumatoid arthritis. Review of the 9/19/16 annual MDS assessment showed the resident had a brief interview for mental status (BIMS) score of 9 (moderately impaired), had no evidence of delirium, had minimal depression with	F 274	**Corrective Actions :** Significant change assessments have been completed for Resident #10 and Resident #39. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** The Interdisciplinary Team will be educated on the guidelines for determining significant change in status per the RAI manual. **Monitoring** The Director of Reimbursement or Designee will conduct audits on four completed MDS's each week to ensure MDS is a significate change MDS if needed. Audits will be weekly for four weeks and then monthly for two months. Audits will be discussed by the Administrator/Director of Reimbursement at monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendations of continuation/ discontinuation of audit.	2/13/17

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F 274	Continued From page 4 a score of 2, had no swallowing disorders, and had an identified non-physician prescribed weight loss. The following concerns were identified: a. Review of section C of the 12/20/16 quarterly MDS assessment showed the resident was not able to participate in a BIMS assessment and was identified as having short term memory loss, and the resident was severely cognitively impaired. Further, the resident was coded to have displayed inattention constantly, disorganized thinking behavior was present and fluctuated, and altered level of consciousness behavior was present and fluctuated. b. Review of section D of the 12/20/16 quarterly MDS assessment showed the resident had a depression score of 3. c. Review of section K of the 12/20/16 quarterly MDS assessment showed the resident had swallowing disorders of holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and continued to have weight loss that was not physician prescribed. d. Interview with the MDS coordinator on 1/12/17 at 3 PM revealed she was unsure if a significant change assessment should have been completed. 2. Review of the medical record showed resident #10 was admitted to the facility on 9/11/15. Review of the 12/16/16 quarterly MDS assessment showed the resident had diagnoses which included non-Alzheimer's dementia and senile degeneration of the brain. Review of the 9/17/16 annual assessment showed the resident had a BIMS score of 6 (severely impaired), had no evidence of depression, had no wandering present, and had no falls since admission or prior to the assessment. The following concerns were	F 274		

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F 274	Continued From page 5 identified: a. Review of a progress note dated 11/11/16 and timed 10:45 PM showed the resident was found outside under a tree. At that time, the resident stated "I can't eat, my gums are sore, and I just want to lay here and die." b. Review of a progress note dated 11/21/16 and time 11:45 PM showed the resident was "pacing hallways" and did not want to go to bed because it was "full of diseases." c. Review of a progress note dated 12/9/16 at 4:25 PM showed a "wander guard [device used to prevent the resident from leaving the facility without assistance]" was placed on the resident's walker. d. Review of section C of the 12/16/16 quarterly MDS assessment showed the resident had a decline in BIMS score to 3 (severely impaired). e. Review of section D of the 12/16/16 quarterly MDS assessment showed the resident had a depression score of 9 (mild depression). f. Review of section E of the 12/16/16 quarterly MDS assessment showed the resident had no wandering present. g. Review of section G of the 12/16/16 quarterly MDS assessment showed the resident declined from being independent with no assistance needed to supervision with set-up help in the areas of bed mobility, transfer, and walk in room. Further, the resident declined from supervision with no support to limited assistance of 1 person in the area of personal hygiene. h. Interview with the MDS coordinator on 1/12/17 at 3 PM revealed a significant change could have been completed for the resident; however, the facility did not see the resident as truly declining.	F 274		

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F 274	Continued From page 6 3. Review of the "CMS RAI version 3.0 manual, October 2014," showed "...04, Significant change in status assessment (SCSA) (A0310A=04)... other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when " ...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care, This REQUIREMENT is not met as evidenced	F 282	**Corrective Actions:** Care plans for Resident #39 and Resident #68 have been reviewed and updated and care is being provided in accordance with the written plan of care. The fall mat for Resident #68 has been discontinued. The care plan goal for Resident #68 regarding hydration has been revised.	2/13/17

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F 282	Continued From page 7 by: Based on observation, staff and family interview, policy and procedure review, and medical record review, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 18 sample residents (#39, #68) The findings were: 1. Review of the quarterly MDS assessment dated 11/17/16 showed resident #68 had diagnoses that included seizure disorder/epilepsy, unspecified intellectual disabilities, heart failure, and acute kidney failure. The resident required the total assistance of two staff members for bed mobility, transfers, and toilet use and, in addition, the total assistance of one staff member for dressing, eating, and personal hygiene. Review of the care plan showed the resident was at risk for falls related to his/her mental status and impaired balance and was also at risk for dehydration due to his/her mental deficiency diagnosis, his/her need for thickened liquids and dependence on staff for food and fluids. The following concerns were identified: a. Review of the care plan goal for dehydration initiated on 9/19/15 showed the resident needed 1646 to 1976 milliliters (56 to 67 ounces) of fluids daily. In addition, the care plan showed that a fall mat was to be placed on the floor when the resident was in bed to prevent injury from a potential fall. b. Observation on 1/10/17 between 9:15 AM and 11:05 AM and 1/11/17 at 1:55 PM, showed the resident was in bed without a fall mat on the floor beside the bed. c. Interview with RN #1 on 1/11/17 at 2:15 PM revealed the fall mat should have been placed on the floor when the resident was in bed. The RN placed the fall mat on the floor at that time.	F 282	**Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** Nursing staff will be educated by the DON or Designee on following the written plan of care and documentation of fluid intake. The Activity Director has educated the Activity Department on inviting residents to attend activities and completing the resident participation logs to include if the resident accepted or declined to attend the activity when invited. **Monitoring:** The DON or Designee will audit four residents weekly to ensure fluid intake documentation has been completed and the resident's plan of care is being followed. See F248 for additional audits. Audits will be completed weekly for four weeks and then monthly for two months. Audits will be discussed by the DON/Designee and the Activity Director/Designee at monthly QAPI meeting for review and recommendation of continuation/discontinuation of audit.	

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F 282	Continued From page 8 d. Review of the November 2016 TAR (treatment assessment record) revealed the resident was to be offered fluids between meals. The start date was 11/17/16. Further review showed 15 of 28 opportunities were marked not applicable and 4 were left blank. Review of the December 2016 TAR showed 22 of 62 opportunities were marked not applicable and 2 were left blank. Review of the January 2017 TAR showed 2 of 20 opportunities were marked not applicable. e. Review of the facility policy titled "Resident Hydration and Dehydration Prevention" revised December 2016 showed "6. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Water pass will be completed each shift. Intake will be documented in the medical records, if ordered/recommended." f. Interview with the RD on 1/11/17 at 9:47 AM revealed that she was responsible for monitoring fluid intake and confirmed the resident was not receiving enough fluid according to the documentation. g. Interview with CNA #1 on 1/11/17 at 2 PM revealed she did give the resident fluids, but she did not document it. Further, she stated she should be doing so and will start. h. Interview with the DON on 1/12/17 at 2:15 PM confirmed that the documentation of fluid intake did not meet her expectations and "not applicable" was not an option for this task. In addition, she stated the nurses and the dietitian are responsible for following up on fluid intake. 2. Review of the 12/20/16 quarterly MDS assessment showed resident #39 had minimal depression, required total assistance of 1 person for locomotion on and off the unit, and had	F 282		

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F 282	Continued From page 9 diagnoses that included Parkinson's disease and rheumatoid arthritis. Review of the "Quality of Life" care plan last revised on 7/1/16 showed the resident needed assistance to and from activities, and interventions which included to encourage the resident to participate in activities. The following concerns were identified: a. Observation on 1/10/17 at 9:16 AM showed the resident was in bed and did not participate in the activities during that morning. b. Observation on 1/12/17 at 8:55 AM showed an unidentified activity assistant was rounding in the dining room and asking residents if they would like to attend the morning activity "energize." Continued observation showed resident #39 was not offered the activity. c. Interview with the resident's daughter on 1/9/17 at 4:30 PM revealed the facility had, in the past, taken the resident to activities and allowed him/her to watch. The resident appeared to enjoy watching the activities; however, the facility no longer did that. d. Interview with the activities director on 1/12/17 at 2:45 PM revealed the resident would gesture if s/he wanted to attend activities and staff should offer the residents the opportunity to participate in activities.	F 282		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure	F 312	Corrective Actions: Residents #7, #10, #14, #23, #54, #57, #68, #73 are receiving the required assistance for bathing.	2/13/17

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F 312	Continued From page 10 required assistance for bathing was provided for 8 of 15 sample residents (#7, #10, #14, #23, #54, #57, #68, #73) who required assistance with ADLs. The findings were: 1. Review of the 12/16/16 quarterly MDS assessment showed resident #57 had diagnoses that included cardiovascular accident and acquired absence of the left foot. Further review showed the resident required extensive assistance of 1 staff member for bathing. The following concerns were identified: a. Interview with the resident on 1/11/17 at 4:07 PM revealed s/he never refused showers because there were 2 scheduled per week and staff did not always give them. Further, the resident stated at times it had been 7 days between showers and that made him/her feel self-conscious after s/he'd exercised and sweated. The resident said s/he felt dirty and concerned s/he "stinks." b. Review of the 12/16/16 quarterly MDS showed the bathing activity did not occur during the 7-day look back period. c. Review of the bathing records showed the resident did not receive a bath or shower for 7 days between 10/15/16 and 10/22/16, 7 days between 10/22/16 and 10/29/16, 7 days between 11/9/16 and 11/16/16, 10 days between 12/7/16 and 12/17/16, and 10 days between 12/21/16 and 12/31/16. 2. Review of the 12/18/16 quarterly MDS assessment showed resident #10 had diagnoses that included Non-Alzheimer's dementia and senile degeneration of the brain. Further, review showed the resident required extensive assistance of 1 person for bathing. The following concerns were identified:	F 312	**Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** DON or Designee with educate nursing staff responsible for bathing on bathing schedules and procedure for resident refusals. A Resident bathing tracking tool will be developed and implemented to monitor bathing schedules and completion of bathing. **Monitoring:** DON or Designee will audit four resident bathing records weekly to ensure bath was completed. In addition, four random residents will be interviewed weekly to ensure their bathing preferences are being honored. Audits will be completed weekly for four weeks and monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/ discontinue audit.	

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F 312	Continued From page 11 a. Review of the bathing record showed the resident did not receive a bath or shower for 18 days between 11/13/16 and 12/1/16, 13 days between 12/1/16 and 12/14/16, 9 days between 12/14/16 and 12/23/16, and 7 days between 1/4/17 and 1/11/17. 3. Review of the 10/25/16 quarterly MDS assessment showed resident #7 had diagnoses that included seizures, subdural hemorrhage, and delirium. Further review showed the resident required total assistance of 2+ person for bathing. The following concerns were identified: a. Review of the bathing record showed the resident did not receive a shower or bath for 7 days between 11/10/16 and 11/22/16, 6 days between 11/28/16 and 12/5/16 with a refusal on 12/1/16, 7 days between 12/6/16 and 12/13/16, 16 days between 12/13/16 and 12/29/16 with a refusal on 12/15/16, 6 days between 12/29/16 and 1/5/17. 4. Review of the 12/21/16 annual MDS assessment showed resident #54 had diagnoses that included Alzheimer's Disease, mental disorder, and decreased mobility. Further review showed the resident required total assistance of 2+ person for bathing. The following concerns were identified: a. Review of the bathing record showed the resident did not receive a bath or shower for 10 days between 11/3/16 and 11/14/16, 7 days between 11/14/16 and 11/22/16, 7 days between 12/5/16 and 12/13/16. 5. Review of the 11/17/16 annual MDS assessment showed resident #68 did not receive a shower during the 7 day look-back period. Review of the facility bathing documentation for	F 312		

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F 312	Continued From page 12 November 2016 revealed the resident received a bath 4 times that month on 11/8, 11/23, 11/26, and 11/30. Review of the bathing documentation for December 2016 revealed the resident received a bath 4 times that month on 12/7, 12/10, 12/24, and 12/31. 6. Review of the 12/20/16 significant change MDS assessment showed resident #14 required the total assistance of 2 staff members for bathing. Review of the bathing documentation for December 2016 revealed the resident received a bath 6 times that month on 12/1, 12/5, 12/15, 12/20, 12/26, and 12/29. 7. Review of the 12/3/16 quarterly MDS assessment showed diagnoses for resident #73 included paralysis. Review of the care plan, revised 12/12/16, showed the resident required extensive assistance with bathing and dressing. Review of the 11/1/16 to 1/11/17 bathing documentation revealed the resident did not receive or refuse baths/showers during the following time periods: From 11/13/16 to 11/24/16 (11 days), 11/27/16 to 12/7/16 (10 days), from 12/8/16 to 12/15/16 (7 days), from 12/18/16 to 12/25/16 (7 days), and from 1/7/16 to 1/11/16 (4 days). 8. Review of the 12/9/16 annual MDS assessment showed resident #23 required extensive assistance with bathing, hygiene, and dressing. Review of the care plan, revised 12/9/16, showed the resident required assistance with ADLs due to cognitive impairment. Review of the 12/1/16 to 1/11/17 bathing documentation revealed the resident did not receive or refuse baths/showers during the following time periods: From 12/4/16 to 12/10/16 (6 days), from 12/24/16	F 312		

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F 312	Continued From page 13 to 12/28/16 (4 days), and from 1/4/17 to 1/11/17 (7 days). 9. Interview with the unit manager on 1/12/17 from 11:30 AM to 11:45 AM revealed residents were scheduled to have 2 showers per week and had to have a minimum of 1 shower per week. Further interview revealed the lack of a system for ensuring residents received baths and showers.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure pressure ulcer care and treatment were implemented in a timely manner for 1 of 2 residents (#73) with pressure ulcers. This failure resulted in the worsening of a	F 314	**Corrective Actions:** Care and treatment has been implemented for Resident #73's pressure ulcer. The non-slip pad has been removed from Resident #73's chair. A pressure re-distributing chair cushion is in place. **Others Potentially Affected:** All residents with pressure ulcers have the potential to be affected by this practice. **Systemic Changes:** The DON will educate licensed nurses on the Prevention of Pressure Ulcers policy. A weekly Skin and Nutrition Meeting will be implemented with nursing leadership and the RD in attendance to review all current pressure ulcers for evaluation, recommendations, and treatment plan review/ revision if indicated. A Pressure Injury Tracking tool will be implemented and completed weekly to ensure treatments are initiated timely and the RD assessment has been completed timely.	2/13/17

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F 314	Continued From page 14 pressure ulcer for resident #73. The findings were: Review of the 12/3/16 quarterly MDS assessment showed resident #73 was not cognitively impaired, was at risk for developing pressure ulcers, required extensive assistance with bed mobility, and was totally dependent with transfers. Review of the care plan, revised on 12/12/16 showed staff were directed to reposition the resident every two hours while in bed and when up in the electric scooter. This review revealed the resident did not have mobility and sensation below the waist including the lower extremities due to paralysis. Review of the care plan and November 2016 to January 2017 daily nursing notes revealed the resident resisted staff efforts to offload him/her with frequent repositioning when up in the electric scooter. This review also revealed the resident refused to take rest periods out of the electric scooter during the day. Review of the Weekly Wound Documentation Form showed a pressure ulcer developed on the right ischium on 12/6/16. This review also showed the following measurements: 2.4 cm (centimeters) x 0.8 cm x 0.3 cm on 12/6/16, 0.9 cm x 3.1 cm x 0.3 cm on 12/20/16, 0.2 cm x 2.4 cm x 0.3 cm on 12/27/16, 0.5 cm x 3.8 cm x 0.4 cm on 1/3/17, and 0.8 cm x 3.0 cm x 0.3 cm on 1/7/17. Review of the wound care nurse's 12/6/16 documentation showed the pressure ulcer was a stage II with no drainage and 100% pink viable tissue wound bed. Review of the wound care nurse's 1/3/16 documentation showed the pressure ulcer had declined to a stage III with serosanguinous drainage, no tunnelling, and 75% thin yellow slough with 25% granulation on the wound bed. Interview with the unit manager on 1/11/17 at 5 PM revealed an indwelling urinary catheter was	F 314	Monitoring: The DON or Designee will audit all pressure ulcers weekly to ensure treatment has been ordered and initiated timely and the RD assessments have been completed. Audits will be completed weekly for four weeks and then monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/discontinue audit.	

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F 314	Continued From page 15 inserted on 12/9/16 to prevent the right ischial pressure ulcer from being saturated with urine during incontinent episodes. She further stated the catheter caused the development of an additional pressure ulcer in the resident's genital area, and the catheter was discontinued on 1/5/17. Review of the Weekly Wound Documentation Form showed the pressure ulcer caused by the catheter was first noted on 12/29/16 and described as an intact blister. This review showed the pressure ulcer measured 0.5 cm x 1.4 cm with no depth on 1/3/17, then progressed to a stage II, measuring 6 cm x 2 cm x 0.3 cm on 1/10/17. The following concerns were identified: a. Observation of both pressure ulcers with LPN #1 on 1/11/17 at 4:10 PM revealed the two areas were as documented on 1/3/17. b. Review of the December 2016 wound care treatment record showed the nurses applied Calmoseptine (an ointment for minor bruises) to the right ischium pressure ulcer from 12/6/16 until 12/10/16 (4 days). Review of the physician's orders, dated 12/10/16, showed a treatment order for Collagen Powder and Hydrogel Silver and cover with a dry dressings. Further review showed this treatment was ordered daily and as needed. c. Review of the dietary note showed a dietary assessment regarding nutritional needs to promote pressure ulcer healing was not done until 1/10/16 (35 days after the resident developed the right ischium pressure ulcer). Further review revealed the assessed nutritional needs included adding protein supplements to the resident's diet. d. Interview with the unit manager on 1/11/17 at 5 PM revealed the wound care nurse talked with staff about the positioning non-slip	F 314		

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F 314	Continued From page 16	F 314		

pad that was placed on the pressure-relieving chair cushion. According to the unit manager, the wound care nurse told staff the resident needed a chair cushion that provided pressure redistribution and a support device that did not secure the resident in a non-pressure relief position for prolonged periods of time in the same manner as the non-slip pad did. The unit manager stated she did not remember the exact date of the conversation with the wound care nurse; however, no actions had been taken regarding the wound care nurse's recommendations.

e. On 1/11/17 from 11:20 AM to 1:30 PM, the resident was observed in his/her room sitting in the electric scooter on the cushion with the support device. During the observation staff did not offer to reposition the resident. At 1:30 PM the resident went with the activity staff on a shopping trip and returned at 3 PM. Interview with activity assistant #1 on 1/11/17 at 4 PM revealed the resident remained in the electric scooter while on the shopping trip and was not repositioned from 1:30 PM to 3 PM.

f. Interview with the DON on 1/12/17 at 1:56 PM revealed she was unable to provide evidence that the Collagen-Hydrogel treatment was initiated earlier than 4 days after the pressure ulcer developed; the nutritional assessment had been done earlier than 35 days; and the pressure relief cushion and support positioning device had been re-evaluated prior to the 1/9/17 to 1/12/17 survey.

g. Review of the policy titled, "Prevention of Pressure Ulcers", revised February 2014, showed the general guidelines included the following: Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin,..decline in

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F 314	Continued From page 17 nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed.	F 314		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323	**Corrective Actions:** Water temperatures have been adjusted and are below 110 degrees (F). **Others Potentially affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** Water heater has been adjusted and regulated to maintain water temperatures below 110 degrees (F). **Monitoring:** Maintenance Director or Designee will audit four random rooms weekly to ensure water temperatures are below 110 degrees (F). Audits will be completed weekly for four weeks and then monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/ discontinue audit.	2/13/17

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure water temperatures were below 120 degrees Fahrenheit (F) for 3 of 4 hallways (200, 300, 400) with resident rooms. The findings were: 1. Observation of the 400 Hall on 1/12/17 showed the following: a. At 10:20 AM the temperature of the bathroom sink hot water in room 402 measured 123 degrees F. b. At 10:24 AM the temperature of the bathroom sink hot water in room 411 measured 122.3 degrees F. 2. Observation of the 300 hall on 1/12/17 showed the following: a. At 10:30 AM the temperature of the bathroom sink hot water in room 306 measured 120.2 degrees F. 3. Observation of the 200 hall on 1/12/17 showed the following: a. At 9:48 AM the temperature of the bathroom sink hot water in room 201 measured 121.3 degrees F. b. At 10:38 AM the temperature of the bathroom sink hot water in room 201 measured 122.3 degrees F. c. At 9:52 AM the temperature of the bathroom sink hot water in room 214 measured 121.1 degrees F. d. At 11:40 AM the temperature of the bathroom sink hot water in room 214 measured 121.8 degrees F. 4. Interview with the maintenance assistant on	F 323		

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F 323	Continued From page 19 1/12/17 at 10:45 AM revealed the facility checks water temps regularly and has an acceptable range on their "TELS" program of 108 to 114 degrees Fahrenheit. Further, he confirmed the temperatures were out of range and he was unsure why they were so high.	F 323		
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to ensure residents received food that was palatable and at appetizing temperatures. The facility census was 88. The findings were: 1. Concerns about food and meal service were identified during the following resident interviews and observation of meal service; a. Interview with resident #57 on 1/11/17 at 11 AM revealed s/he gets a room tray and it takes a long time for the food to be delivered. By the time the tray is received, the hot food is cold and it doesn't taste good. Further, the resident stated if the food was delivered timely it would be at the appropriate temperature and foods the resident didn't like could be tolerated. b. Group interview with 9 residents on	F 364	**Corrective Actions:** Residents will receive food that is palatable and at appetizing temperatures. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** The Registered Dietitian has educated the Dietary Department on: - Point of Service Temperatures, keep steam table turned up, keep plate warmer on (use hot pads), keep foods covered as much as possible while on the steam table,Take end of service temps, Use different thermometers if you are getting unusual readings. The RD will keep minutes of the food committee meetings and complete grievances if indicated to address concerns, promote follow up, and resolution of any food related concerns.	2/13/17

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F 364	Continued From page 20 1/10/17 at 1 PM revealed, "The food is not hot, they have to bring it over from the 100 hall. Then it sits there until they get all the people into the dining area." c. Observation on 1/12/17 at 8:24 AM in the small dining area showed hot cereal with approximately 1/4 inch of clear liquid on top of a white substance. Interview with resident #62 at that time revealed biscuits and gravy, and cream of wheat was on the menu. S/he further stated, "the gravy is thin and runny." d. Interview with resident #32 during the meal observation on 1/12/17 at 8:24 AM revealed, "the biscuits tasted like bread and the gravy is watery. I'm not real happy with the food today. It puts me in a bad mood when it's not ok to eat." e. An interview on 1/11/17 at 12:30 PM with resident #73 revealed food was not hot because s/he ate in his/her room and the room trays were served last. f. Interview with resident #63 on 1/11/17 at 1:45 PM revealed the food tasted "okay", but sometimes the hot food was cold and the cold food was not as cold as it should be. 2. On 1/10/17 at 6:55 PM, a sample tray was tested after all of the residents were served. Cook #1 was observed testing each food item. This observation revealed the temperature of the cooked green beans was 103 degrees Fahrenheit (F), the ziti was 130 degrees F and the ham salad was 64 degrees F. 3. Interview with the RD on 1/11/17 at 10:45 AM revealed she had been aware of some of the resident concerns about the food since November 2016. She stated concerns were discussed during the food committee meetings.	F 364	**Monitoring:** The RD or Designee will conduct weekly random audits of point of service food temperatures. In addition, the RD or Designee will interview four residents a week to ensure food is palatable and at appetizing temperatures. Audits will be conducted weekly for four weeks and monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/discontinue audit.	

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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 364	Continued From page 21 She stated staff and residents attended the meetings, and discussed the concerns, but she did not have records of the meetings. She also stated she did not have information about dates of identified concerns, measures implemented to address concerns, resolution timeframe, and follow-up discussions with the residents.	F 364		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441	**Corrective Actions:** No immediate correction could be taken for Resident #39's cares or the linen handling in which infection control practices were not followed. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** The DON or Designee will educate nursing staff on proper linen handling and perineal care. **Monitoring:** The DON or Designee will complete weekly audits on perineal care and linen handling to ensure infection control practices are being followed. Audits will be completed weekly for four weeks and then monthly for two months. Audits will be reported to monthly QAPI for review and recommendations to continue/discontinue audit.	2/13/17

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 01/12/2017

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F 441	Continued From page 22 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure infection control practices were followed for 1 of 6 residents (#39) during	F 441		

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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
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F 441	Continued From page 23 perineal care and 1 random observation of linen handling. 1. Observation 1/9/17 at 4:11 PM showed CNA #2 and CNA #3 entered resident #39's room to provide care and get the resident up for dinner. The CNAs rolled the resident towards the wall and CNA #2 pulled down the resident's pants. CNA #2 told CNA #3 the resident had been incontinent of stool and the resident's pants were soiled. CNA #3 removed the pants and without placing them in a bag laid the pants on a cloth chair in the resident's room. CNA #2 removed the resident's brief and wiped the resident using a gloved right hand. After wiping the resident, the CNA used the soiled hand and reached into the wipe container to remove more wipes. The CNA continued to wipe the stool off of the resident and then reach into the wipe container to obtain more wipes. 2. Observation on 1/11/17 at 10:54 AM showed CNA #4 was in room 402 changing the bed linen. The CNA had a cart in the room with unbagged clean linen placed on top of the cart. The CNA placed the dirty linen in a bag and placed it on the bottom of the cart. The CNA then left the room with the cart and took it into the utility room. 3. Interview with the DON on 1/12/17 at 12:16 PM revealed staff should not have touched the clean wipes with a soiled hand or placed soiled clothing on the chair. Further, she revealed clean and soiled items should be bagged and they should not be transported together.	F 441		