STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING _____ B. WING _____	C 01/25/2018

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GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 000	INITIAL COMMENTS A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 1/23/18 through 1/26/17. The survey was prompted by complaint intakes WY00002352, WY00002360, and WY00002472. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set MAR- Medication Administration Record PRN- Pro Re Nata (as needed) RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553		3/8/18

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

Electronically Signed | 02/19/2018

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F 553	Continued From page 1 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of facility policy and procedure, the facility failed to ensure 1 of 18 sample residents (#18) was provided the right to participate in his/her care planning process. The findings were: Interview with resident #18 on 1/24/18 at 9:44 AM revealed s/he was not invited to any meetings related to his/her care, and the resident stated s/he wished to be included and share ideas. The following concerns were identified: a. Interview with unit manager #1 on 1/25/18 at 9:54 AM revealed the family or power of attorney for residents were usually sent a letter inviting them to attend the scheduled care plan meetings. The unit manager was uncertain if	F 553	1. No immediate action could be taken for Resident #18. 2. All residents are at risk to not be invited to their care plan meetings. 3. The care plan team will be educated by the Director of Nursing (DON) or designee on the requirement of inviting residents to their care plan meetings and documenting this invitation. 4. DON or designee will audit all care plan meetings per week to ensure the resident was invited to their care plan meeting and that this invitation is documented. Audits will be weekly for six weeks and then monthly for two months. Results of audits will be discussed by the DON at the monthly Quality Assurance Process	

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F 553	Continued From page 2 residents were invited to the meetings. She stated those in attendance were documented in the summary notes in the electronic medical record. b. Review of the 1/22/18 Care Conference Summary for resident #18 showed s/he was cognitively intact with a BIMS score of 13. The attendance section showed the resident and resident representative were not in attendance for the meeting. Review of the medical record failed to show notes related to the resident or family being invited to the care conference. c. Review of the "Care Planning" policy and procedure last revised November 2017 showed "5...Resident/Resident Representative will be invited to the care conference. This will be documented in a "Care Plan" progress note. The care conference is intended to be an interactive meeting with the resident, resident representative(s), and interdisciplinary team representatives to review the care plan, clarify service and contact information, and to provide a forum for the resident/or resident representative(s) to relate satisfaction or dissatisfaction with care..."	F 553		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(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	F 637		3/8/18

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F 637	Continued From page 3 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 RAI manual review, the facility failed to ensure a significant change MDS assessment was completed for 1 of 4 residents (#2) with significant changes. The findings were: Review of the 7/7/17 admission MDS assessment, the 10/19/17 quarterly MDS assessment, and the 1/19/18 quarterly MDS assessment for resident #2 revealed the following concerns: a. Review of the 7/7/17 admission MDS assessment showed the resident's cognitive status was 6/15 on the brief interview for mental status (BIMS), indicating severe cognitive impairment. Review of the 10/19/17 quarterly MDS assessment showed the resident scored a 4/15 on the BIMS. Review of the 1/19/18 quarterly MDS assessment showed the resident had declined to a score of 0/15, and further showed the resident could not be assessed because s/he was rarely or never understood. b. Review of the 7/7/17 admission MDS assessment and 10/19/17 quarterly MDS assessment showed the resident required supervision for set-up from one staff member with ADLs which included bed mobility and transfer. The 10/19/17 quarterly MDS assessment showed limited assistance of one person for dressing. Review of the 1/19/18 quarterly MDS assessment revealed the resident had declined and required extensive assistance of 2 staff for the following ADLs: bed mobility, transfer, dressing, and toileting.	F 637	1. Resident #2□s MDS□s will be modified to reflect a significant change. 2. All residents are at risk for not having major declines or improvements identified and having the corresponding assessments completed with that change. Director of Clinical Reimbursement will review all residents who had an MDS in the last quarter that did not experience a significant change. Modifications will be completed on findings if needed. 3. The Director of Clinical Reimbursement will educate MDS staff on what constitutes a significant change and what requires an MDS modification. 4. The Director of Clinical Reimbursement will audit five random residents each week to ensure a significant change MDS assessment has been completed for any resident with a significant change. Audits will continue weekly for six weeks and then monthly for three months. Results of audits will be discussed by the Director of Clinical Reimbursement or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	

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F 637	Continued From page 4 c. Review of the 1/7/17 admission MDS assessment and 10/19/17 quarterly MDS assessment showed the resident was occasionally incontinent of urine. Review of the 1/19/18 quarterly MDS assessment revealed the resident had become frequently incontinent of urine. d. Review of the 1/7/17 admission MDS assessment showed the resident weighed 193 lbs. Review of the 10/19/17 quarterly MDS showed the resident weighed 180 lbs., a 6.74% decline. Review of the 1/19/18 quarterly MDS assessment revealed the resident weighed 166 lbs., a 7.78% decline from the 10/19/17 quarterly assessment. In addition, the resident had a 14.17% decline in 6 months between the 1/7/17 admission MDS assessment and the 1/19/18 quarterly MDS assessment. e. Interview with CNA #1 on 1/26/18 8:24 AM revealed the resident was independent with cares on admission, but currently required extensive assistance from staff. f. Interview with the DON on 1/26/18 at 9:47 AM confirmed a significant change MDS was required for the resident regarding increased cognitive impairment, weight loss, ADL decline, and increased frequency of incontinence. g. Review of the "CMS RAI version 3.0 manual, October 2016, 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,	F 637		

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F 637	Continued From page 5 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 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		3/8/18

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F 657	Continued From page 6 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and medical record review, the facility failed to ensure care plans were developed and revised to meet the individual care needs for 2 of 18 sample residents (#2, #37). The findings were: 1. Interview with resident #37 on 1/24/18 at 4:35 PM revealed s/he had pain related to a prolapsed rectum, an old right shoulder injury, and arthritis in the right knee. The resident stated pain medications and heat packs were helpful for the pain. The resident also talked about having injections in the past for pain control in the shoulder and the knee. Review of the 5/4/17 admission pain interview/assessment showed the shoulder, knee and rectal prolapse were sources of pain for the resident. The assessment also showed PRN pain medication and heat were effective means of pain relief. The following concerns were identified: a. Review of the care plan for pain showed it was updated on 12/29/17. The care plan only addressed the prolapsed rectum and failed to show any interventions other than "balance daily activity and rest to aide in comfort" and "assists to alleviate prolapse as much as possible when needed." b. Interview with DON on 1/26/18 at 11:43 AM verified the care plan for pain was not developed and "it could be better."	F 657	1. Resident #37 has a pain care plan implemented and updated to his current pain interventions. Resident #2 has specific behaviors that require Haldol administration and non-pharmalogical interventions have been added to the care plan. 2. All residents are at risk to have missed updates/lack of development on their plan of care. All resident will have their care plans reviewed for accuracy and updated accordingly. 3. The DON or designee will review with the IDT the examples cited in the deficiency, as well as, educate the IDT on the care plan policy and the requirement to develop a care plan which is accurate based on the resident's care needs and to update the care plan when changes occur. The IDT will meet every weekday morning and will discuss any resident changes and update care plans as necessary. 4. The DON or designee will audit five random care plans per week, including residents #2 and #37, to ensure plans of care are updated as changes occur and are accurate to the care the resident is receiving. Audits will be done weekly for six weeks and then monthly for three	

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F 657	Continued From page 7 2. Medical record review showed resident #2 was admitted on 6/23/17 with diagnoses which included non-Alzheimer's dementia and depression. Review of the resident's December 2017 and January 2018 MARs revealed the resident had a 10/27/17 order for Haldol (anti-psychotic medication) by mouth as needed every 12 hours. Review of the care plan showed a plan for administration of Haldol. The interventions for the "Nurse Aide" were: "1. Report unusual behavior to nurse, 2. Report changes in physical condition to nurse, 3. Report changes in appetite to nurse, 4. Report pain indicators to nurse, 5. Encourage activity, 6. Check skin with cares, 7. Offer fluids with cares, 8. Establish regular bedtime." "The interventions for the "Nurse" were: 1. Assess functional level, 2. Monitor for effects of medication on daily function, 3. Provide adequate pain control, 4. Assure safety at all times." The following concerns were identified: a. The facility failed to identify specific behaviors and failed to address non-pharmacological interventions in the care plan related to the behaviors. b. Interview with the DON on 1/26/18 at 9:47 AM confirmed the facility failed to ensure non-pharmacological interventions were a part of the resident's care plan, and the plan did not specify the behaviors that required administration of Haldol.	F 657	months. Results of audits will be discussed by the DON at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and	F 685		3/8/18

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F 685	Continued From page 8 hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide timely assistance with obtaining hearing devices/services to 1 of 1 sample residents (#34) with a lost hearing aide. The findings were: Observation on 1/24/18 at 3:45 PM showed resident #34 had only a left hearing aide, and the resident was hard of hearing. Review of an administration note dated 1/18/18 at 1:26 PM showed "Assure both hearing aides are accounted for, place in am, off in pm one time a day for placement missing right hearing aide, resident has left hearing aide in ear at this time. right hearing aide has been missing since 1/01/2018, both hearing aides were present on day shift of 1/01/2018." The following concerns were identified: a. Interview on 1/25/18 at 10:47 AM with RN #1 stated they had not found the hearing aide and they had not initiated an appointment yet to possibly get a new one. She stated a note would be in the record related to family notification. b. Review of the medical record showed a note dated 1/25/18 at 11:26 AM that the family was notified of the missing hearing aide. c. Interview with the DON on 1/26/18 at 10:58	F 685	1. Resident #34 has both hearing aides. 2. All residents with hearing aides are at risk to not have their necessary equipment in place. All residents with hearing aides will be audited to ensure that they have their hearing aides and that they are being used appropriately. 3. The DON or designee will educate all nursing staff on ensuring that residents with hearing aides are wearing their hearing aides and if something happens to a resident's hearing aides notifying family and administration. 4. The DON or designee will audit all residents with hearing aides weekly to ensure they have their necessary equipment and they are being used. Audits will be weekly for six weeks and then monthly for three months. Results of audits will be discussed by the DON at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	

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F 685	Continued From page 9 AM verified the family should be notified within the week an item such as a hearing aide goes missing. She also verified there was not an earlier note related to the family notification.	F 685		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and	F 756		3/8/18

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F 756	Continued From page 10 maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure pharmacist recommendations were acted on for 4 of 18 sample residents (#2, #35, #38, #47). The findings were: 1. Medical record review showed resident #2 had diagnoses which included non-Alzheimer's dementia and depression. Review of the resident's December 2017 and January 2018 MARs revealed the resident had an order for Haldol (anti-psychotic medication) by mouth (PO) PRN (as needed) every 12 hours. The order start date was 10/27/17 for 5mg PO every 12 hours as needed, and was changed on 12/19/17 to 2.5 mg PO every 12 hours as needed, and changed again on 1/19/18 back to 5mg PO every 12 hours as needed. The following concerns were identified: a. Review of an 11/30/17 pharmacist "Consultation Report" showed the following recommendation: "Please discontinue PRN Haloperidol [Haldol]. If the medication cannot be discontinued at this time, current regulations require that the prescriber directly examine the patient to determine if the antipsychotic is needed, document the diagnosed specific condition being treated, the intended duration of therapy, and the rationale for the extended time period prior to issuing a new order." The DON signed the report on 12/21/17 and wrote, "Haldol	F 756	1. Residents #2,35,38 and 47 will have their physicians contacted regarding the noted medications and the physician asked about a GDR for the medication. If the physician wishes to continue the medication, the physician will see the resident, document the diagnosis, provide rationale, and a specified duration for the use of the medication. 2. All residents on psychotropic meds are at risk for not having appropriate GDRs for their medications with supported rationale from the physician. All residents on psychotropic medications will be audited to ensure that they have the appropriate GDR documentation and rationale. 3. The DON or designee will educate all licensed nurses on the requirement of having GDRs for residents on psychotropic medications and the facility's responsibility to ensure the GDR is followed up on with the appropriate rationale. 4. The DON or designee will audit all GDRs monthly to ensure that there is appropriate follow up and rationale if the medication is continued. These audits will continue monthly for six months. Results of audits will be discussed by the DON at monthly QAPI Meeting to identify trends or	

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F 756	Continued From page 11 was lowered to 2.5mg Q12H [every 12 hours] PRN." The physician failed to sign or write a rationale on the report. Further medical record review revealed the physician failed to address the pharmacist recommendation in any other part of the record. b. Review of a 12/27/17 pharmacist "Consultation Report" showed the following comment: "REPEATED RECOMMENDATION from 11/30/17. Please respond promptly to assure facility compliance with Federal regulations. [Resident's name] has a PRN order for an antipsychotic medication. Haloperidol 1 tab ORALLY TWICE DAILY AS NEEDED FOR anxiety, agitation." The physician signed the recommendation on 1/18/18 and failed to document a rationale. The answer from the physician was "GDR is not recommended for this patient." Review of the entire medical record showed no additional information or rationale from the physician that addressed the resident's Haldol PRN order. 2. Medical record review showed resident #35 had diagnoses which included Alzheimer's disease. Review of a 10/18/17 pharmacist "Consultation Report" showed the following recommendation, "[The resident] receives an antipsychotic Seroquel/quetiapine with DX alzheimer's and is due for GDR. Please review diagnosis as well as further consideration of GDR as soon as possible." The physician signed the report on 12/20/17 and documented no detailed rationale. The physician documented, "Stable on current meds." The pharmacist also completed a 11/30/17 "Consultation Report" with the same exact recommendation. The physician signed the report on 1/17/18 and documented "Continue current therapy." Review of physician orders	F 756	additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	

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F 756	Continued From page 12 showed the original order for Seroquel was dated 4/29/17 for 25mg by mouth at 5 AM and 75 mg at 5 PM. The order was changed to an increase on 12/23/17 to 50mg at 5 AM and 75 mg at 5 PM. Review of the entire medical record revealed no rationale for continuing and increasing the resident's Seroquel. 3. Medical record review showed resident #38 had diagnoses which included Alzheimer's disease and unspecified psychosis. Review of the 10/18/17 pharmacist "Consult Report" showed the following comment: "REPEATED RECOMMENDATION from 9/19/17: Please respond promptly to assure facility compliance with Federal regulations. [Resident's name] has received lorazepam, and buspirone HCL. Both due for GDR-please review at psych meeting while also reviewing Quetiapine for GDR." The physician signed the report on 12/17/17 and documented "Will D/C [discontinue] Daytime Ativan." Review of the medical record revealed the resident's Ativan order was changed as stated, and the buspirone HCL was also discontinued. However, the physician failed to address the request for a GDR for the Quetiapine (antipsychotic). The orders for Quetiapine during the review were "Seroquel [quetiapine] 50 mg PO at 5 AM dated 7/22/16, Seroquel 25 mg PO at 12 PM dated 10/6/16, and Seroquel 50mg PO at 5 PM dated 7/21/16. 4. Review of the 11/18/17 quarterly MDS assessment showed resident #47 had diagnoses including Alzheimer's disease and psychotic disorder. In addition the assessment showed the resident was given antipsychotic, antianxiety, and opioid medications in the 7-day look back period. The following concerns were identified:	F 756		

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F 756	Continued From page 13 a. Review of the pharmacy consultation reports showed reviews for: 9/1 to 9/20/17, 10/1 to 10/30/17, 11/1 to 11/30/17. In these reviews the physician response to the recommendations was, "GDR is contraindicated for this resident," and "GDR is not recommended for this patient." The physician failed to document a rationale as to why the GDR was not attempted. b. In addition the 11/1/17 through 11/30/17 consultation report showed "Repeated recommendation from 10/1817, 9/19/17, 8/23/17, and 7/14/17: Please respond promptly to assure facility compliance with Federal regulations. [S/he] has an order for quetiapine and lorazepam. Both due for a gradual dose reductions." 5. Interview with the DON on 1/26/18 at 9:47 AM confirmed the facility failed to ensure a GDR was attempted or a detailed rationale from the physician was documented, regarding the pharmacist recommendations.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		3/8/18

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F 758	Continued From page 14 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medication regimens were free from unnecessary antipsychotic medications for 1 of 1 sample resident (#2). The findings were:	F 758	1. Resident #2's physician has been contacted in regard to the PRN Haldol. If the physician orders the continuation of the medication, a rationale will be obtained from the physician and the	

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F 758	Continued From page 15 Medical record review showed resident #2 had diagnoses which included non-Alzheimer's dementia and depression. Review of the resident's December 2017 and January 2018 MARs revealed the resident had an order for Haldol (anti-psychotic) by mouth (PO) PRN (as needed) every 12 hours. The order start date was 10/27/17 for 5mg PO every 12 hours as needed, and was changed on 12/18/17 to 2.5 mg PO every 12 hours as needed, and changed again on 1/19/18 back to 5mg PO every 12 hours as needed. Review of the entire medical record, which included pharmacist recommendations on 11/30/17 and 12/27/17, revealed the physician failed to assess the resident for Haldol PRN usage, and failed to document a rationale for continued PRN use. Interview with the DON on 1/26/18 at 9:47 AM confirmed the facility failed to ensure the physician assessed the resident and documented a rationale for continuation of the order for Haldol PRN.	F 758	physician will see the resident. 2. All residents on psychotropic meds are at risk for not having appropriate GDRs for their medications with supported rationale from the physician. All residents on psychotropic medications will be audited to ensure that they have the appropriate GDR documentation and rationale. 3. The DON or designee will educate all licensed nurses on the requirement of having GDRs for residents on psychotropic medications and the facility's responsibility to ensure the GDR is followed up on with the appropriate rationale. 4. The DON or designee will audit all residents on psychotropic medications monthly to ensure that they have a GDR and that the GDR is followed up on with appropriate rationale if the medication is continued. These audits will continue monthly for six months. Results of audits will be discussed by the DON at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F 803		3/8/18

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F 803	Continued From page 16 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, review of diet cards/orders, and staff interview, the facility failed to ensure the menu was followed for 26 residents who resided on the memory care unit (#2, #3, #4, #6, #9, #12, #23, #25, #27, #28, #35, #38, #47, #49, #50, #55, #61, #64, #68, #69, #70, #71, #72, #79, #88, #89). The findings were: Review of the planned menu for 1/25/18 showed the evening meal included a bacon, lettuce and tomato sandwich, chicken noodle soup, and mixed vegetables. The portion size for the mechanical soft and the regular diets were the same. The menu showed the sandwich was 2 pieces of bread, 3 slices of bacon, 2 slices of tomato and 1 lettuce leaf. The portion for the soup was 6 ounces and the mixed vegetables	F 803	1. No immediate action could be taken for the residents listed in the deficiency. 2. All residents are at risk of not receiving the accurate portions based on their diets. 3. The Administrator or designee will educate all dietary staff, including the dietary manager on following menus and ordered portion sizes. 4. The Administrator or designee will audit 5 meals per week to ensure that menus and portion sizes are being followed. These audits will be weekly for six weeks and then monthly for three months. Results of audits will be discussed by the Administrator or designee at monthly QAPI Meeting to identify trends or additional education	

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F 803	Continued From page 17 was 1/2 cup. The portion sizes for the puree diets were 6 ounces of pureed soup, 4 ounces of pureed sandwich and 1/2 cup of pureed mixed vegetables. The following concerns were identified: a. Review of the memory care diet cards/orders showed 24 residents with regular or mechanical diets (#2, #3, #4, #6, #9, #12, #23, #25, #27, #28, #35, #47, #49, #50, #55, #64, #68, #69, #70, #71, #72, #79, #88, 89). Observation on 1/25/18 at 5:32 PM showed the BLT sandwich had been substituted for ham salad, and residents with a regular or a mechanical diet received 1/2 of a ham salad sandwich, 4 ounces of soup, and 1/2 cup of vegetables. b. Review of the memory care diet cards/orders showed 2 residents with pureed diets (#38, #61). Observation on 1/25/18 at 5:32 PM showed the scoops for the pureed items which were verified at that time by cook #1, were 4 ounces for the sandwich, 4 ounce of vegetables, and 4 ounces of soup. c. Interview with the dietary manager and the kitchen supervisor on 1/26/18 at 9:43 AM revealed the residents on the memory care unit were always served 1/2 of a sandwich due to their small appetites. However, they verified the diet cards did not reflect small portions for their diets. They also confirmed all residents received less than the planned portion size for the soup.	F 803	needs and will include discussions on the continuation or discontinuation of the audit based on findings.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		3/8/18

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F 812	Continued From page 18 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitation requirements were met related to the condition of food equipment and the dating of health shakes in 1 of 2 kitchens (the main kitchen). The findings were: 1. Observation of the main kitchen on 1/23/18 at 2:23 PM showed 60 undated thawed health shakes located in a refrigerator near the service line. According to the instructions on the cartons, the shakes were to be used within 14 days of being thawed. 2. Observation in the main kitchen at 4:57 PM showed there were food equipment items that need to be replaced because they were unable to be cleaned effectively. These include 5 cutting boards which were scored from use, one plastic pitcher with fissures inside the bottom, the cutting surface of the serving line. 3. Interview with the dietary manager and the kitchen supervisor on 1/26/18 at 9:43 AM verified	F 812	1. The undated health shakes have been discarded. The food equipment items listed have been replaced. 2. All residents are at risk of consuming undated health shakes. All health shakes in the facility will be audited to ensure they are dated properly. All food equipment will be inspected to ensure they do not need replaced. Any equipment noted in disrepair will be replaced accordingly. 3. The dietary manager or designee will educate all dietary staff on dating health shakes and ensuring that all food equipment is kept in good repair. 4. The dietary manager or designee will audit all health shakes for appropriate dating and all food equipment to ensure it is in good repair weekly. The audits will continue for six weeks and then monthly for six months and then quarterly thereafter. Results of audits will be discussed by the dietary manager at monthly QAPI Meeting to identify trends or	

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F 812	Continued From page 19 the expectation was for an expiration date to be placed on each carton for health shakes. They also acknowledged items in poor condition with fissures and scored cutting surfaces needed to be replaced. 4. According to Food Code 2013, U.S. Public Health Service 4-101.11: "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be ...(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." 5. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	F 812	additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		3/8/18

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F 883	Continued From page 20 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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F 883	Continued From page 21 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to implement a system for ensuring pneumococcal and influenza immunizations were offered for 4 of 5 sample residents (#22, #29, #40, #61) reviewed for immunizations. The findings were: 1. Review of the 11/1/17 quarterly MDS assessment showed resident #22 was admitted to the facility on 5/17/17 with diagnoses which included diabetes mellitus, hypertension, and anemia. The assessment was documented as "not offered" for the pneumococcal vaccine, and the area for whether or not the vaccine was up to date was left blank. 2. Review of the 11/9/17 quarterly MDS assessment showed resident #29 was admitted to the facility on 4/21/16 with diagnoses which included hypertension, non-Alzheimer's dementia, and depression. The assessment was documented as "not offered" for the influenza vaccine, and the area for the last vaccine date was left blank. Medical record review of a form titled, "Update Immunization" revealed the most recent influenza immunization for the resident was on 10/19/16. 3. Review of the 11/27/17 quarterly MDS assessment showed resident #40 was admitted	F 883	1. Resident #29 will be offered the influenza vaccine if the resident meets the health requirements for the vaccine. Residents # 22, 40 and 61 will have the status of their pneumococcal vaccine determined and if appropriate be offered the vaccine. 2. All residents are at risk of not receiving or being offered the pneumococcal and influenza vaccines. All residents will be audited to determine their status of the vaccines and offered if appropriate. 3. The DON or designee will educate all licensed nurses on the requirement of offering the pneumococcal and influenza vaccines. 4. The DON or designee will audit all new residents weekly to ensure that their status of the influenza and pneumococcal vaccination was found out and a vaccine offered if appropriate. The DON or designee will update the IDT at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	

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F 883	Continued From page 22 to the facility on 6/6/15 with diagnoses which included heart failure, hypertension, diabetes mellitus, and depression. The assessment was documented as "yes" for the pneumococcal immunization being up to date. However, the actual date was left blank. Medical record review of a form titled, "Update Immunization" revealed the date for the pneumococcal vaccine was left blank. 4. Review of the 12/19/17 significant change MDS assessment showed resident #61 was admitted to the facility on 11/24/15 with diagnoses which included cancer, hypertension, arthritis, osteoporosis, and Alzheimer's dementia. The assessment was documented as "yes" for the pneumococcal immunization being up to date. However, the actual date was left blank. Medical record review of a form titled, "Update Immunization" revealed the date for the pneumococcal vaccine was left blank. 5. Interview with the infection preventionist on 1/26/18 at 12:20 PM confirmed residents #22, #40, and #61 had not received the pneumococcal vaccine, or the facility failed to determine the status. She further confirmed the last influenza vaccine was administered to resident #29 on 10/19/16, and she was not certain why the facility failed to ensure the resident received the vaccine this influenza season. 6. According to the policy titled, "Pneumococcal Vaccination-Resident/Patient" last revised November 2016, "Purpose: To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on	F 883		

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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 883	Continued From page 23 Immunization practices (ACIP)...Procedure: ...2. Each resident's immunization status will be determined prior to vaccination, and will be documented in their individual medical record." 7. According to the policy titled, "Influenza Vaccination-Resident/Patient" last revised May 2014, "Policy: Recognizing the major impact and mortality of influenza disease on residents of nursing homes and the effectiveness of vaccines in reducing health care costs and preventing illness, hospitalization and death, this facility had adopted the following policy statements: 1. All residents will be offered and encouraged to receive the influenza vaccine annually, unless there is documented contraindication or they have already received the vaccine for that individual season."	F 883		