STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on January 31, 2018. Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the Alzheimer building (SCU). The facility had a capacity of 75 certified Medicaid beds with a census of 60 residents.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with 2012 NFPA 101, Life Safety Code. The findings were:	K 211	1. The laundry room corridor and other corridors have been cleared of the noted items and are free of obstructions. 2. Admin or designee will audit all corridors to ensure they are free of	3/9/18

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

Electronically Signed | 02/14/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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

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K 211	Continued From page 1 Observation on 1/31/2018 at 10:19 AM in the Laundry Room corridor revealed a congested corridor with a pallet of medical supplies blocking access to the exit. Further observation revealed congested corridors with patient lifts blocking access to the exits throughout the facility. The means of egress must be continuously maintained free of obstructions to prevent potential injury or death, and to allow full use in case of emergency. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101, Sections: 19.2.1; 7.1.10.1; 4.5.3.2	K 211	obstructions. 3. Administrator or designee will educate all staff in regards to keeping the corridors clear of all obstructions. 4. Administrator or designee will audit all corridors three times per week to ensure that they are free of obstructions. Audits will be weekly for six weeks and them monthly for three months. Results of audits will be discussed by the Administrator at monthly Quality Assurance Process Improvement Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		3/9/18

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	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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

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K 222	Continued From page 2 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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GOSHEN HEALTHCARE COMMUNITY	**2009 LARAMIE STREET** **TORRINGTON, WY 82240**

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K 222	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exits in accordance with 2012 NFPA 101, Life Safety Code. The findings were: 1. Observation on 1/31/2018 at 10:23 AM at the main entrance revealed delayed egress signage was not provided to describe delayed egress operation. Further observation revealed an automatic door sign, and when tested the door would not open automatically. Failure to post proper signage could delay egress through exit doors which could result in injury or loss of life. Interview with the Facility Maintenance Manager at the time of observation indicated the automatic door had been disconnected, and he was unaware of the requirement. REF: 2012 NFPA 101, Sections: 19.2.2.2.4(2); 7.2.1.6.1.1(4) 2. Observation on 1/31/2018 at 10:46 AM at the Laundry exit door revealed that the right door exceeded 30 pounds of force to open. Further observation revealed that the bottom of the door had been damaged, and was catching on the ground. Failure to maintain exit doors as required could delay egress from the building during an emergency resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated he was aware of the requirement. REF: 2012 NFPA 101, Sections:19.2.2.2.1: 7.2.1.4.5	K 222	1. Main entrance has delayed egress signage. The automatic door signage has been removed. The door at the laundry exit has been repaired and now opens properly. 2. Administrator or designee will audit all exit doors to ensure they operate properly and have the appropriate signage. 3. Maintenance staff will be educated by Administrator or designee on that all exit doors operate appropriately and have the proper signage. 4. The Administrator or designee will audit all exit doors weekly to ensure they are operating appropriately and have proper signage. Audits will continue 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 needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
K 233	Clear Width of Exit and Exit Access Doors	K 233		3/9/18

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	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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GOSHEN HEALTHCARE COMMUNITY	**2009 LARAMIE STREET TORRINGTON, WY 82240**

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K 233 SS=D	Continued From page 4 CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear width of exits in accordance with the 2012 NFPA, Life Safety Code. The findings were: Observation on 1/31/2018 at 11:00 AM in the Beauty Shop adjacent to the Activities Room revealed that the exit was partially blocked by the open Activities Room door. When measured the Beauty Shop had a clear width of exit access of 29". Further observation revealed that this was the primary exit from the Activities Room. Interview with the Facility Maintenance Manager at the time of observation indicated that the Activities Room had two additional exits that could be used, and he was unaware of the requirement. Failure to maintain exit width as required could delay egress during an emergency resulting in injury or death. REF: 2012 NFPA 101, Section: 19.2.3.6	K 233	1. The doors to the activity room by the beauty shop have been removed. 2. Administrator or designee will audit all doors in the facility to ensure they are able to be used accordingly and are not blocked. 3. The Administrator or designee will educate all maintenance staff on ensuring that doors are not blocked and that they are able to be used as exits. 4. The Administrator or designee will audit all doors to ensure they are not being blocked monthly. This audit will be monthly for six months. Results of audits will be discussed by the Administrator 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.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		3/9/18

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K 321	Continued From page 5 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosure in accordance with the 2012 NFPA 101, Life Safety Code. The findings were: Observation on 1/31/2018 at 11:26 AM in Room 410 (Showroom) revealed a room larger than 50 square feet that was being used as a storage area for resident furniture. Further observation	K 321	1. The room noted in the deficiency is no longer being used as a storage room. 2. Administrator or designee will audit all storage rooms to ensure they meet the requirement. 3. The Administrator or designee will educate all maintenance staff on requirements for storage areas. 4. The Administrator or designee will audit	

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	535057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/31/2018**

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K 321	Continued From page 6 revealed the door did not have a self-closing device. Failure to maintain hazardous enclosures as required could allow fire spread resulting in injury or death. Interview with the Facility Maintenance Manager at the time of observation indicated the room was used as a Showroom, and not meant for storage. He was aware of the requirement. REF: 2012 NFPA 101, Sections: 19.3.2.1; 8.7.1.3	K 321	all storage areas monthly to ensure they meet all requirements. This audit will be done monthly for 6 months. Results of audits will be discussed by the Administrator 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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	535057	A. BUILDING **02 - ALZHEIMERS BUILDING** B. WING _____	**01/31/2018**

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GOSHEN HEALTHCARE COMMUNITY	**2009 LARAMIE STREET TORRINGTON, WY 82240**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on January 31, 2018. Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 2008. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the Main Building (NH). The facility had a capacity of 28 certified Medicaid beds with a census of 28 residents. Based upon the findings of the survey team, it was determined the building meets the Life Safety Code standards based on compliance with all provisions.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/14/2018

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.

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Licensing and Surveys on January 31, 2018. Based upon the findings of the survey team, it was determined the facility was in compliance with all Emergency Preparedness requirements.	E 000		

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

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