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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/21/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled 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 in the attic and an addressable fire alarm system.	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were: Observation on 5/21/09 at 9:52 AM revealed the automatic closing device attached to the corridor	K 029	K 029 The automatic closing device attached to corridor door leading to the clean laundry side was adjusted by maintenance staff on 5/21/09 . This was documented by photographs. This will be monitored monthly by safety walk through and reported to Safety committee quarterly. POC ACCEPTED BY FAX FORM DN 6/29/09. SIGNED ORIGINAL COPY RECEIVED & APPROVED W/ NATALIE KORELL, NHA.	5/21/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Korell — TITLE: Administrator — (X6) DATE: 6/28/09

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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10/29/09

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K 029	Continued From page 1 door leading to the clean side of the laundry did not latch the door into its frame with three attempts. Interview with the director of plant operations at the time of observation revealed all corridor doors were inspected quarterly. Inspections are scheduled for the second week of the quarter and the last inspection occurred on 4/06/09. Despite the facility's maintenance plan, however, the director of plant operations was unaware this door closure did not function as required.	K 029		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review, observation and staff interview the facility failed to conduct fire drills on one of three shifts and staff members were not familiar with emergency procedures in 2 of 6 smoke compartments. The findings were: 1. Review of the fire drill records revealed the second shift occurred between 2 PM and 10 PM. Further review revealed a drill had not occurred on the second shift during the first quarter of 2009.	K 050	K 050 1. Discussion with State surveyor determined that the drills were scheduled during the 6 to 2 shift and it was later determined they had changed the staff schedules without communicating the change. The drill in question had been conducted within the correct times. Drill schedule will be monitored monthly by Director of Plant Ops and Fire Safety Officer and will be reported to Safety committee quarterly. CURRENTLY THE SECOND SHIFT OCCURS BETWEEN 1PM & 9:30 PM. A FIRE DRILL WAS CONDUCTED ON 2/19/09 @ 122 PM. MNTL. STAFF WILL STAY INFORMED OF CURRENT SHIFT CHANGES.	6/9/09

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K 050	Continued From page 2 2. Interview with director of plant operations on 5/21/09 at 2:35 PM revealed he was unaware there had not been a fire drill on second shift during the first quarter. He stated the drill was probably missed because of an error with scheduling. 2. Observation of the fire drill on 5/21/09 at 2:56 PM revealed the corridors were not cleared of obstructions when the fire alarm system was activated. The nursing staff left three Hoyer lifts in the 300 hall and one Hoyer lift in the 400 hall throughout the drill. An intercom page was not given as indicated in the fire policy. Interview with three Certified Nurse Aides (CNAs) on the 300 hall after the drill revealed they were unaware that the corridors were to be cleared whenever the fire alarm system was activated. Interview with the 300 hall nurse revealed she did not know how to perform an intercom page.	K 050	K 050 2. Halls were cleared on 5/21/09 and staff education on 8' egress will be completed by 7/1/09. Fire drill education will be conducted by Fire Safety Officer every month during New Employee Orientation with mandatory annual training for all staff conducted by FSO each summer. These trainings will be documented and monitored monthly by Director of Plant Ops and reported to Safety committee quarterly.	7/1/09
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation and staff interview failed to ensure three of seven sprinkler system test were performed and failed to ensure sprinkler heads were free of obstructions in 2 of 6 smoke compartments. The findings were: 1. Review of the sprinkler system testing records revealed the waterflow, supervisory signal and	K 062	K 062 1. Director of Plant Ops contacted contracted fire system inspection company and told them inspections need to be scheduled and completed within each quarterly period. Will be monitored quarterly through document review by Plant Ops Director and Fire Safety Officer and reported to Safety quarterly. K 062 3. Sprinkler head in 200 hall janitor closet was replaced on 6/9/09 by maintenance staff. All sprinkler heads will be inspected during quarterly safety walk through and will be reported to Safety quarterly.	6/30/09 6/9/09

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K 062	Continued From page 3 main drain devices were not tested during the fourth quarter of 2008. 2. Interview with the director of plant operations 5/21/09 at 2:35 PM revealed the sprinkler system was tested by an outside contractor. He further stated that he was unaware the system had not been tested during the fourth quarter of 2008. 3. Observation on 5/21/09 at 11:17 AM revealed the sprinkler head in the 200 hall janitors' closet was corroded. Interview with the director of plant operations revealed the sprinkler system was not inspected annually for corrosion or foreign material. 4. Observation on 5/21/09 at 11:50 AM revealed the outdoor sprinkler head above the 400 hall exit door had residue of mud on the frame, operating element, and orifice ring. The vinyl siding next to the head was also marked with mud. Interview with the director of plant operations revealed a bird built a nest on the sprinkler head each year and the staff had to remove it whenever discovered.	K 062	K 062 4. 400 hall outdoor sprinkler head was replaced by maintenance staff on 6/9/09 and maintenance will install approved sprinkler head cages on all side pennant sprinklers. This will be monitored by quarterly safety walk through and reported to safety quarterly.	7/5/09
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1,	K 074	K 074 1. Curtains in beauty shop were removed by the beautician on 5/21/09. Curtains in the administrator's office will be removed by 6/12/09 and will be sprayed with approved fire resistant chemical before being reinstalled. Fire rating documentation will be available.	7/5/09

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K 074	Continued From page 4 NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure curtains were flame retardant in 2 of 6 smoke compartments. The findings were: 1. Observation on 5/21/09 between 11 AM and 12 PM revealed the curtains in the administrators office and the beauty shop lacked flame retardant documentation. 2. Interview with the director of plant operations on 5/21/09 at 11:24 AM revealed he was aware all loose hanging curtains were required to be flame retardant. He further reported there was no flame retardant documentation to review for the aforementioned curtains.	K 074	K 074 2. Director of Plant Ops will send out a notification to all staff stating that all furnishings and loose hanging material must be accompanied with fire resistant documentation and this documentation must be filed in the maintenance office. This documentation will be monitored through quarterly safety walk through and reported to safety quarterly.	7/5/09
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure temporary wiring did not replace permanent fixed wiring in 1 of 6 smoke	K 147	K 147 The surge protectors in the financial offices were removed and replaced by finance staff with surge protectors approved by maintenance staff. This will be monitored by quarterly walk through and reported to safety quarterly.	5/21/09

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K 147	Continued From page 5 compartments. The findings were: Observation on 5/21/09 at 9:45 AM revealed the financial offices had two locations were the computer was plugged into a surge protector which was, itself, plugged into another surge protector. Interview with the director of plant operations revealed the electrical equipment in offices were not routinely inspected.	K 147		
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure alcohol based hand rub (ABHR) dispensers were not installed above or adjacent to ignition sources in 2 of 6 smoke compartments. The findings were: 1. Observation on 5/21/09 between 10 AM and 11	K 211	K 211 1. Maintenance staff removed ABHR dispensers from above or adjacent to light switches in resident rooms 203, 206, and 209 and in the dining room nutrition center and placed 12" or more away from the light switches and /or any ignition source. Staff will be educated on this and this will be monitored by monthly safety walk through and reported to safety quarterly.	7/5/09

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K 211	Continued From page 6 AM revealed ABHR dispensers were installed above or adjacent to light switches in resident rooms #203, #206, #209 and the dining room nutrition center. 2. Interview with the director of plant operations on 5/21/09 at 10:39 AM revealed he was aware ABHR dispensers could not be installed above or within twelve inches of an ignition source. He also reported room inspections were conducted by the maintenance staff on a quarterly basis, the last inspection occurred during the week of 4/06/09. These inappropriate ABHR installations had not been identified by maintenance staff. Interview with the nursing staff of the 200 hall at the same time revealed the dispensers have been in place for more than six months.	K 211	K 211 2. Director of Plant Ops and Care Center Director of Nursing have discussed more efficient options than the little ABHR dispensers they are presently using. These dispensers will be monitored by safety through quarterly walk through and reported to safety quarterly.	7/5/09