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

PRINTED: 01/12/2009
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 _____ B. WING _____	C 12/29/2008

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
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and family and staff interviews, the facility failed to provide treatment and services to promote healing and prevent the development of new, avoidable, pressure sores for one (#43) of three sample residents with pressure sores. The findings were: According to the 12/17/08 significant change Minimum Data Set (MDS) assessment, resident #43 had a Stage II pressure sore and a history of pressure sores within the past 90 days. However, the only treatments listed were dressings and medications to the area. Review of the care plan, updated on 12/24/08, showed the resident had a Stage II pressure sore on the buttock, which was to be covered with an Allevyn dressing. The care plan also instructed staff to observe the resident's skin every shift for signs and symptoms of pressure ulcers and to provide perineal care "at least once each shift and after each incontinent episode." A note on the care plan dated 12/24/08 described the pressure sore area as "red but not open." The documentation also noted that a "pressure relieving cushion has been ordered" for	F 314	Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable: and a resident having pressure sores receives necessary treatment and services promote healing, prevent infection and prevent new sores from developing. Resident #43 had a pressure relieving gel cushion added to her wheelchair and to her recliner on December 29, 2008. The staff will observe the resident's skin every shift for signs and symptoms of pressure ulcers. Peri-care is provided by staff each time the resident is toileted using Comfort Shield barrier cloth at least once each shift and after each incontinent episode and Baza cream as a preventative measure. A Physical Therapy evaluation of her coccyx wound was completed on January 5, 2009 and indicated "only mild very superficial abrasion type area remaining. No need for PT wound care. Nursing to continue dressing changes PRN until healed. Allevyn dressings continue to be utilized with documentation reflective of healing.	

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

Melodie Kovell, Temporary Nursing Home Administrator for Goshen Care Center 1/21/09

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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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J8R311 Facility ID: WY0010 If continuation sheet Page 1 of 4

This POC accepted on 1/28/09 @ 1650 c all additions & corrections per phone conversation c Norman Knoch, RN, BSN & Betty Nelson, RD. State Health Surveyor.

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F 314	Continued From page 1 the resident's recliner. Observation on 12/29/08 at 1 PM showed the resident was continent of bowel but needed assistance with perineal care. The resident was alert and oriented when conversing with staff and the surveyor. Further observation showed the resident had a dressing on the right buttock. A reddened area approximately one centimeter (cm) long by 0.8 cm wide was on the left buttock with a circular open area approximately 0.2 cm in diameter in the middle of the reddened tissue. The surrounding skin was rough and flaky. During the observation, certified nurse aide (CNA) #3 provided perineal care and confirmed the area on the left buttock was open. On 12/29/08 at 1:16 PM registered nurse (RN) #5 observed the wound on resident's buttocks and stated the open area on the left buttock was not present when she last worked on 12/26/08. She stated she received no information about it from the previous shift and had no idea how long it had been open. The RN reported the open area on the right buttock was healed on 12/26/08. The RN stated the open wound on the left buttock looked as if it contained feces. At 1:25 PM, RN #5 removed the dressing and cleansed the resident's coccyx and buttocks. The gauze was slightly yellowed when she finished. After the slough tissue was removed, five separate open areas, including the original pressure sore, were revealed. Three were on the right buttock and two were on the left. They ranged in size from 0.2 cm to 1.3 cm in diameter, with the original pressure sore measuring 0.8 cm by 0.3 cm. The resident agreed to remain in bed after the pressure sores were cleansed and treated. The following concerns were identified: a. Observation on 12/29/08 at 1:25 PM showed the resident had two one-inch pieces of	F 314	The care plan of Resident #43 has been updated to reflect current intervention utilized for treatment and prevention of pressure ulcers. bw Systemic changes: 1) Wound Care Committee has been established and will meet monthly to ensure the continued monitoring of all residents with referrals to the appropriate physician and/or Physical Therapy for all residents bw 2) Daily skin check sheet has been implemented to be signed by each CNA and nurse on duty during each 24 hour period. If wounds are found, the res. is visually the nurse, the MD is notified & orders are implemented. bw 3) Bath aid completes inspection of skin twice weekly during resident baths to ensure a thorough inspection of each resident. 4) Physical Therapy and Restorative Care working together to provide daily overview of resident for all skin care issues. PT is educating restorative staff in preventative measures & prophylactic bw 5) Additional pressure relieving devices have been ordered. 6) Pressure relieving and position devices will be maintained in stock. 7) Inventory and tracking sheet has been initiated and will be maintained for each resident. for preventive skin breakdown devices bw 8) New hourly rounding program has been initiated and implemented. for the 4P's The 4P's are positioning, pain assm't personal needs, & placement of items bw	01/19/09 bw

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F 314	Continued From page 2 foam tacked together and placed in the reclining chair. A blue cushion covered with a pillowcase and partially filled with air was in the wheelchair; however, it had deflated to the point that no pressure relief was provided. At that time RN #5 stated the cushion was from restorative services, but the foam had been provided by the family. At 1:44 PM, restorative aide #11 stated the blue cushion did not come from the facility; it had also been provided by the family. At 4:15 PM that day, the director of nursing (DON) confirmed the foam in the recliner was not an acceptable pressure reducing device. The DON also verified the blue cushion in the wheelchair was too deflated to provide pressure relief. On 12/30/08 at 10:32 AM, a family member stated the family had provided both cushions in an attempt to reduce pressure on the sores while the resident was sitting. The family member further stated the resident "hated" to lie down. b. On 12/29/08 at 1:46 PM the MDS coordinator confirmed a "pressure relieving cushion" was ordered two to three weeks prior but had not yet arrived. At 2:05 PM the coordinator stated the facility replaced the blue cushion in the wheelchair with a pressure reducing one, but she had no idea why it was not done sooner. c. Although the care plan instructed staff to observe for signs and symptoms of pressure sores during every shift, there was no system for reporting these observations to the charge nurse or wound team. d. Review of the care plan showed removing pressure from the pressure sore area was not addressed. Review of the medical record showed a regime that was acceptable to the resident for removing pressure from the open areas was not discussed. e. The facility failed to determine if providing	F 314	9) Nurse to nurse and CNA to CNA reporting have been replaced with team reports with all shift staff participating to increase communication completely to all team members. 10) All pressure relieving devices brought from the resident's home will be inspected by the wound care nursing staff and only these devices that are approved by the wound care team may be used. 11) All care plans for each resident's care will include measures related to prevent pressure ulcers formation. Quality monitoring will be done monthly by members of the Wound Care Team and reported at least quarterly to the QA committee 12) Residents found @ Stage I are treated per facility protocol.	01/22/09

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F 314	Continued From page 3 perineal care once every shift was sufficient to maintain cleanliness of the pressure sores.	F 314	This page left blank intentionally	