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 09/05/2019

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 complaint survey was conducted by Healthcare Licensing and Surveys on 9/5/19. The survey was prompted by complaint intake WY00002933. The following common abbreviations are used throughout this document. DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		10/18/19

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

Electronically Signed | 09/27/2019

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F 580	Continued From page 1 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify a physician and family for 1 of 3 sample residents (#1) with a change of condition. The findings were: 1. Review of the admission MDS assessment dated 7/24/19 showed resident #1 had an admission date of 7/17/19 and diagnoses which	F 580	F580 1. No immediate action could be taken for Resident #1. Resident #1 was taken to the local emergency room by the family on 8/25/2019 and returned to the facility on 8/31/2019. 2. All residents that have a change in	

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F 580	Continued From page 2 included coronary artery disease, heart failure, hypertension and cerebral infarction due to embolism. a. Review of the progress notes from 7/17/19 to 7/20/19 showed no lower extremity edema was present. Review of the progress notes from 7/21/19 to 8/8/19 showed the resident had "pitting edema" in bilateral lower extremities. Further review showed the facility initiated thromo-embolic deterrent (TED) hose on 7/31/19. There was no evidence the physician and/or family was notified of the edema presence or use of TED hose. b. Review of the progress notes from 8/12/19 to 8/20/19 showed edema was present to the bilateral lower extremities. There was no evidence the physician and/or family was notified of the edema presence. c. Review of a progress note dated 8/22/19 and timed 9:03 PM showed "...Lower extremity edema is present. LLE [left lower extremity] swollen with 2+ pitting edema. Ted hose off at HS [hours of sleep]..." Review of a progress note dated 8/23/19 and timed 9:23 PM showed "...Lower extremity edema is present. Lower extremities-more in LLE. No ted hose on tonight..." Review of a progress note dated 8/24/19 and timed 9:01 PM showed "...Lower extremity edema is present. Some in lower extremities especially in left lower. Ted hose off at HS..." Further review showed there was no evidence the physician and/or family was notified of the edema presence or increase in edema to the left lower extremity. d. Review of a progress note dated 8/25/19 and timed 7:49 AM showed the resident had a "red area" on his/her left foot and the area was "marked with sharpie to monitor" Further review showed "1620 [4:20 PM] Family comes in and	F 580	condition are at risk. 3. DON or designee will educate all nurses on timely notification to physician, resident and resident's family of any change in a resident's physical, mental or psychosocial status, the process for notifying physicians during off hours and on weekends, and the use of the SBAR and Risk Management system. This education will be completed by 10/11/2019. The Nursing Administration team will review all changes of condition during clinical start up to ensure that proper follow up and notification was completed on call changes of conditions. 4. DON or designee will audit all changes of conditions weekly to ensure that they were addressed, monitored and that the appropriate notification was completed per the regulation. 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 Improvement (QAPI) Meeting to identify trends or additional education needs and will include continuation or discontinuation of audits based on the findings. 5. 10/18/2019	

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F 580	Continued From page 3	F 580		

asks about left foot. This nurse communicated that message was left for Dr. [name] @ [at] [location] and that tomorrow we would have an answer. Family decides to take resident to [ER]." The note had a "created" date of 8/25/19 and was timed 4:54 PM. Further review showed there was no evidence the physician received the notification message and/or notification to the family when the area was first observed.

e. Interview with RN #1 on 9/5/19 at 2:52 PM revealed she was the nurse who marked the red area with a sharpie and left a message with the physician. She revealed it was the weekend and she did not expect to hear back from the physician until Monday. She confirmed she did not contact the family and was unsure why the family was concerned. Further interview revealed "usually" she would call the family when the doctor called back and she did not observe the resident's foot at the time of transfer as she was not the nurse assigned to the resident.

f. Interview with RN #2 on 9/5/19 at 3:12 PM revealed he was assigned to the resident on 8/25/19 and had observed the resident's foot at the time of the transfer. Further interview revealed he was not sure who had marked the area and he would have notified the "hospitalist" and had the area assessed at the facility.

g. Interview with the DON on 9/5/19 at 3:18 PM revealed staff were to notify "hospitalists" on the weekends if there was a need for physician notification. She confirmed the resident should have been seen by a hospitalist and the family should have been notified when the area was initially identified.

h. Interview with the DON on 9/5/19 at 4:46 PM revealed she was unable to find documentation a physician was notified when the resident began having edema in his/her lower

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F 580	Continued From page 4 extremities and confirmed she expected nurses to notify physicians of new edema.	F 580		