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 02/13/2020

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 recertification survey was conducted by Healthcare Licensing and Surveys from 2/10/20 through 2/13/20. Also reviewed in the course of the survey were complaint intakes WY00002875, WY00003006, WY00003018, WY00003019, WY00003020, and WY00003021. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set mg: Milligrams NHA: Nursing Home Administrator PRN: Pro re nata (as needed) RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		3/17/20

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

Electronically Signed | 03/11/2020

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 02/13/2020

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 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents were treated in a dignified manner during one random observation. This failure affected 4 of 25 residents in the secure unit (#49, #51, #74, #288). The findings were:	F 550	F550 1. Residents #49, 51, 74, and 288 were assessed for adverse effects of the cited practice and none were found. 2. The facility has and will continue to observe meals regularly as part of our	

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 02/13/2020

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 550	Continued From page 2 1. Observation on 2/12/20 at 8:33 AM showed three staff members were providing assistance with eating to residents #49, #51, #74, and #288 at the assisted dining table. The staff members maintained conversation with each other while providing assistance with the meal; however, the staff members did not engage the residents at any time during the meal. 2. Interview with the NHA on 2/12/20 at 11:24 AM revealed staff not engaging residents while providing assistance with meals had been a concern since November. Further, it was her expectation for staff to interact with the residents while providing assistance.	F 550	quality assurance program. 3. Nursing staff were educated on engaging residents during meal service. 4. The facility has and will continue to observe meals regularly for this practice. Meal observations will be turned into the Administrator for review when complete. Managers will be assigned to meal observations a minimum of five times per week. The Administrator will report the results of the audits to the QA committee monthly x 3 months. Problems with this process will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the comprehensive MDS assessment for 1 of 22 sample residents (#63) with comprehensive assessments. The findings were: Review of the 12/22/19 quarterly MDS assessment showed resident #63 required extensive assistance for ADLs and had 2 unhealed stage 4 pressure ulcers. The following concerns were identified: a. Review of the December 2019 and January 2020 skin evaluations showed the resident did not have any pressure ulcers. b. Review of the 1/9/20 care conference note	F 641	F641 1. The MDS for resident #63 was modified to correct the error. 2. Resident records with similar names were identified and reviewed for similar errors. There were no other errors identified. 3. Admissions, MDS, Medical Records, and Nursing staff were educated on identification and labeling of records for residents with similar or the same names. Medical records with similar or same names will be identified with a “Name Alert” banner on their profile. 4. The Medical Records Director or their	3/17/20

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 02/13/2020

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 641	Continued From page 3 showed the resident's skin was intact. c. Interview with the MDS coordinator on 2/12/20 at 10:01 AM stated the coding of the pressure ulcers was an inaccuracy and she would complete a modification to show there were no pressure ulcers treated for this resident.	F 641	designee will be responsible for identifying resident records with same or similar names. The Medical Records Director will complete a monthly audit of residents with similar names to ensure they are properly labeled and report to the QA committee x 3 months. Problems with this process will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661		3/17/20

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 02/13/2020

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 661	Continued From page 4 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure the discharge summary included a recapitulation of stay for 1 of 1 sample residents (#88) with a planned discharge. The findings were: Review of the 11/14/19 discharge MDS assessment showed resident #88 had a planned discharge with return not anticipated. Review of the 11/14/19 discharge note showed the resident left with family, had medications, equipment/supplies, and belongings. Review of the discharge note and the discharge summary failed to include a recapitulation of the resident's stay. Interview with the NHA and DON on 2/13/20 at 9:30 AM verified the summary lacked the recapitulation of stay.	F 661	F661 1. Resident #88 no longer resides in the facility. 2. Medical records for resident discharged in the last 30 days were reviewed for similar omissions. 3. Nursing staff were educated on the facility's process for discharges to include completion of the discharge summary form. 4. The Director of Nursing is responsible for monitoring this system. The IDT will complete an audit of discharges for completion of the discharge summary prior to discharge. The Director of nursing will complete a monthly audit of discharges x 3 months and report to the QA committee. Problems with this process will be brought to the QA committee for review and resolution.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure effective pain	F 697	F697 1. A pain assessment was completed for	3/17/20

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 02/13/2020

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 697	Continued From page 5 management for 1 of 1 sample residents (#24) reviewed for restorative nursing. The findings were: 1. Review of the 5/10/19 annual MDS assessment and 11/10/19 quarterly MDS assessment showed resident #24 declined in his/her ability to walk, from "extensive assist" to "does not occur." Review of a restorative nursing note dated 8/5/19 showed the resident could walk 10 to 50 feet with a walker, and the restorative program should be continued to maintain balance with walking. The following concerns were identified: a. Review of the "Nursing Rehab" documentation from 1/15/20 to 2/12/20 showed nine attempts were made to provide restorative therapy to the resident. All of these attempts were documented as resident refusals. b. Interview with the restorative aide #1 on 2/12/20 at 2:52 PM revealed she had been unable to provide restorative services for the resident due to frequent refusals related to pain. When that happened, she reported the refusals and pain to the nurse, however she did not typically reapproach the resident for therapy after contacting the nurse. c. Interview on 2/12/20 at 4:34 PM with LPN #1 revealed she was unaware of the resident's complaints of pain. In addition, she stated the resident had not received PRN pain medications since November of 2019. d. Review of the resident's MAR showed the resident had not received any PRN pain medications since 11/2/19. e. Interview with the MDS coordinator on 2/12/20 at 1:48 PM revealed she was given the responsibility of managing the restorative therapy program in December of 2019, however she had	F 697	resident #24 and the care plan was revised. 2. Residents on restorative programs who have refused treatments in the last 90 days were reassessed for pain. Pain regimes and care plans were revised as necessary. 3. Nursing, MDS, and Restorative staff were educated on proper notification, assessment, and pain management for residents whose pain affects their daily living. C.N.A.s and Restorative staff were educated on the importance of proper notification of a licensed nurse for refusals and complaints of pain. 4. The Director of Nursing is responsible for monitoring this system. The Director of Nursing or designee will complete regular audits of medical records to identify uncontrolled pain and refusals of restorative care. Audits will occur weekly x 4 weeks and then monthly thereafter. The DON will provide a report to the QA committee monthly x 3 months. Problems with this system will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	

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 02/13/2020

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 697	Continued From page 6 not had time to monitor or manage any part of the restorative program. She revealed during this time, none of the residents on restorative therapy were reviewed to determine if the therapy regimen was appropriate based on the residents' abilities. In addition, she had not been notified of any problems from the restorative aide.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure involvement of a legal representative for 1 of 1 sample residents (#65) reviewed who lacked decision-making capability. The following concerns were identified: 1. Review of the 12/23/19 quarterly MDS assessment showed resident #65 had severe cognitive deficits as indicated by a BIMS score of 0 out of 15. The resident's record identified a family member as his/her Power of Attorney (POA) and the responsible party for decisions about the resident's care. The following concerns were identified: a. Interview with RN #2 on 2/10/20 at 3:40 PM revealed the resident had been recently prescribed Seroquel (an antipsychotic), however the medication could not be given until the resident's POA could be contacted. The facility had attempted to call the POA multiple times with no response. b. Review of the resident's medical record	F 745	F745 1. During the survey the facility met with family members of resident #65 who voiced interest in guardianship but did not follow through on appointments. The case is being reviewed by Wyoming Guardianship for assignment of a guardian. 2. Current residents were reviewed for appropriate responsible parties, POA, and/or guardian. Two additional residents were identified and appropriate actions taken to obtain responsible parties/guardians. 3. The facility revised the admission screening process to include verification of responsible party, POA, and/or guardian. The Social Service department and Admissions Coordinator were educated on the new screening process. 4. The Social Service Director is	3/17/20

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 02/13/2020

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 745	Continued From page 7 showed Seroquel was prescribed on 1/21/20, however the medication had not yet been administered. c. Review of a social services progress note dated 2/15/19 showed the facility was aware the contact information for the resident's POA was invalid, however no documented efforts were made to find valid contact information after 2/20/19. d. Interview with the social services director (SSD) on 2/11/20 at 4:48 PM revealed he was made aware of the situation approximately 2 weeks prior. In addition, he was unsure of the details or source of the information about why the resident's POA could not be contacted. In a follow-up interview on 2/13/20 at 11:26 AM, the SSD stated the facility did not have documentation of any POA for the resident. e. Interview with the NHA on 2/13/20 at 9:33 AM revealed the resident could not receive any new medications or treatments without consent from the resident's POA, including the new prescription for Seroquel. She was not aware of any temporary solution to provide new medications or treatments until a POA or guardian could be identified.	F 745	responsible for monitoring this process. The Social Service Director or designee will review the Admissions Confidence Sheet containing responsible party/POA and/or guardianship information prior to admission. The Social Service Director will report on the process to the QA committee monthly x 3 months. Problems with this process will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		3/17/20

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 02/13/2020

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 755	Continued From page 8 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement an effective system for preventing drug diversion. The census was 89. The findings were: 1. Observation on 2/12/20 at 9:50 AM showed the DON's desk had one locked drawer where discontinued narcotic medications were stored until they could be destroyed. The following concerns were identified: a. Multiple observations from 2/10/20 through 2/12/20 showed the DON's office door was open and the office was vacant. b. Interview with the DON on 2/12/20 at 9:50 AM revealed when narcotics were discontinued	F 755	F755 1. No residents were affected by this practice 2. A review of narcotic destruction records was conducted. The narcotic destruction system was changed prior to the survey to meet the current professional standards and regulations. 3. The DON’s office door is now locked when the DON is not present. Nursing staff were re-educated on the narcotic destruction process to include secure storage in the DON office under double lock. A locking cabinet was installed in the DON office to contain the narcotics	

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 02/13/2020

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 755	Continued From page 9 the medications were taken from the medication cart by 2 nurses and placed in the DON's desk until the medications could be destroyed with the pharmacist. Further, she revealed the desk drawer was kept locked, however the second required lock was her office door. The DON acknowledged her office door should be kept locked whenever the office was vacant.	F 755	waiting for destruction. 4. The DON or designee is responsible for monitoring this system. The DON and Consultant Pharmacist will conduct a review and audit of the narcotic destruction system monthly x 3 months. The DON will provide a report to the QA committee monthly x 3 months. Problems with this process will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		3/17/20

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 02/13/2020

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 761	Continued From page 10 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications available for use were not expired in 2 of 4 medication storage units (200 hall medication cart, 500 hall medication cart). The findings were: 1. Observation on 2/13/20 at 8:15 AM of the 200 hall medication cart showed 1 bubble pack of oxybutynin chloride ER (extended release) 10 mg tablets expired on 9/30/19. Interview at that time with LPN #2 revealed the medication was available for resident use and was expired. 2. Observation on 2/13/20 at 8:35 AM of the 500 hall medication cart showed 1 bubble pack of buspirone 10 mg tablets expired on 11/30/19. Interview at that time with RN #1 confirmed the medication was expired and was available for resident use. 3. Interview on 2/13/20 at 9:30 AM with the DON revealed it was the facility's expectation for the medications to be checked weekly and expired medications discarded.	F 761	F761 1. The expired medications were removed from the medication carts at the time they were discovered. 2. Medication cards in all carts were inspected and any and all expired cards of medications were removed. 3. Licensed nurses and Medication Aides were educated on proper medication storage to include inspection of medication cards in the carts as well as other items. 4. The Director of Nursing is responsible to monitor this system. Weekly medication storage audits are conducted by nursing staff. An audit tool is completed and turned into the Director of Nursing. Problems with this system will be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	F 801		3/20/20

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 02/13/2020

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 801	Continued From page 11 required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and	F 801		

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 02/13/2020

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 801	Continued From page 12 nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure qualifications for the dietary manager were met. The census was 89. The findings were: Interview with the dietary manager on 2/10/20 at 10:04 AM revealed she had not completed any educational or certificate program for dietary managers or food service professionals. The manager revealed she had working experience and a food safety education certificate. In addition, the registered dietitian was on a consultant basis. The plan was for the dietary manager to go through training to obtain certification.	F 801	F801 1. No residents were cited. 2. Potentially all residents can be affected by this practice. 3. The Dietary Manager and a second dietary staff member were enrolled in an approved training program for Food Managers through the National Restaurant Association with target date for completion by 3/20/2020. 4. The Administrator is responsible for ensuring qualified individuals are employed by the facility. Annual audits of	

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 02/13/2020

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 801	Continued From page 13 Interview with the NHA on 2/13/20 at 11:53 AM verified the dietary department did not have a manager with the required education or certification.	F 801	personnel files for dietary managers will be conducted by the Administrator or designee to ensure that certifications and education remains current. The Administrator will monitor the progress of the Dietary Manager in completion of the assigned course and exam and report to the QA committee. Problems with this process will be brought to the QA committee for review and resolution. 5. Completion date 3/20/2020	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		3/17/20

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 02/13/2020

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 880	Continued From page 14	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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 02/13/2020

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 880	Continued From page 15 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and professional standard review, the facility failed to ensure effective infection control practices were followed during 2 of 3 wound care observations (#5, #33). The findings were: 1. Review of the 1/12/20 quarterly MDS assessment showed resident #5 had one stage 3 pressure ulcer. Review of physician orders dated 1/3/20 showed the facility was to provide treatment to the right heel once a day for wound healing. The right heel was to be cleaned with wound cleanser, silver alginate applied to the wound, and then covered with gauze. The following concerns were identified: a. Observation on 2/11/20 at 9:59 AM showed LPN #1 and the wound consultant RN performed wound care to the resident's heel. LPN #1 cleaned the scissors and then placed them on an unclean clipboard. A sterile barrier was placed on an over-bed table and the unopened supplies were put on the barrier. LPN #1 donned gloves and cleansed the wound with gauze pads and wound cleaner, removed her gloves, and performed hand hygiene. The nurse donned new gloves and used the contaminated scissors to open a package of 4 by 4 inch gauze pads and continued to treat the wound. b. LPN #1 removed her gloves and without performing hand hygiene retrieved keys to the wound cart from the wound consultant nurse's pocket. After retrieving supplies from the wound cart she donned new gloves without performing hand hygiene, opened a package of cotton swabs, and measured the wound.	F 880	F880 1. Wounds for residents #5 and #33 were assessed for signs of infection. There were no new signs of infection. 2. Current wounds were assessed for signs of infection. 3. Nursing staff were educated on the proper technique for clean dressing changes to include proper storage of gloves, and handwashing before, during, and after the procedure. Licensed nurses completed a skill competency for clean dressing change. 4. The Director of Nursing is responsible for monitoring of this system. The Director of Nursing or designee will complete weekly observations of wound care and document. Problems with performance of the skill will be resolved immediately. The Director of Nursing or designee will report to the QA committee monthly x 3 months. Problems with this process will be brought to the QA committee for review and resolution.	

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 02/13/2020

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 880	Continued From page 16 c. LPN #1 removed her gloves and without performing hand hygiene donned new gloves, opened the wound dressing packets, and used the contaminated scissors to cut the silver alginate gauze. 2. Observation on 2/11/20 at 10:23 AM showed LPN #1 provided wound care to resident #5's left great toe. The following concerns were identified: a. LPN #1 donned gloves and cleaned the wound with wound cleanser and gauze pads. The nurse removed her gloves and without performing hand hygiene donned new gloves and continued to treat the wound. 3. Review of the physician orders for resident #33 showed the facility was to provide treatment to the coccyx once a day with wound cleanser and a TheraHoney sheet (cut to fit) cover with adhesive optifoam dressing, until resolved. The following concerns were identified: a. Observation on 2/11/20 at 1:59 PM showed LPN #1 and the RN wound consultant provided wound care to the resident's coccyx. LPN #1 donned gloves that she had retrieved from her right shirt pocket and continued to provide treatment to the resident's wound. 4. Interview with the wound care nurse on 2/11/20 at 2:18 PM revealed she always took her gloves out of her pocket. 5. Interview with the DON on 2/13/20 at 9:30 AM revealed it was the facility's expectation for the nurses to change gloves and perform hand hygiene between dirty and clean procedures. According to WHO (World Health Organization) found at	F 880		

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 02/13/2020

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 880	Continued From page 17	F 880		

www.who.int/gpsc/5may/Glove_Use_Information_Leaflet.pdf (accessed on 2/25/20) showed "...The use of contaminated gloves caused by inappropriate storage, inappropriate moments and techniques for donning and removing, may also result in germ transmission."

According to the Journal of Wound, Ostomy and Continence Nursing March/April 2012, Volume 39, Issue 2S, pages S30 to S34 showed "Clean technique. Clean means free of dirt, marks, or stains.3 Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous handwashing, maintaining a clean environment by preparing a clean field, using clean gloves and sterile instruments, and preventing direct contamination of materials and supplies. No "sterile to sterile" rules apply. This technique may also be referred to as non-sterile. Clean technique is considered most appropriate for long-term care, home care, and some clinic settings; for patients who are not at high risk for infection; and for patients receiving routine dressings for chronic wounds such as venous ulcers, or wounds healing by secondary intention with granulation tissue."

According to Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills", Seventh Edition, 2008, Page 898: Changing a wound dressing included the following steps in preparation, " ...3. Perform hand hygiene. 4. Gather equipment ...7. Clean Over-bed table. 8. Place sterile supplies on the over-bed table ...10. Place bag for soiled dressings near wound site.

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 02/13/2020

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 880	Continued From page 18 11. Open sterile packages and place on over-bed table. Arrange packages to ensure that you don't cross over the sterile field when using dressings. Rationale: Commercially prepared sterile packages can be opened and used for the sterile field; the inside of the package is sterile. The following steps were included for the procedure: "1. Remove tape ...2. Don clean gloves. 3 Remove soiled dressings, and dispose of in the bag ...4. Obtain wound specimen for culture if ordered. 5. Remove clean gloves ...6. Bring over-bed table close to working area. 7. Open sterile saline ...8. Don sterile gloves ...9. Form a ball with gauze pads ...10. Cleanse wound ...11. Assess wound ...17. Close the plastic bag, and dispose of bag as isolation material. 18. Remove gloves, and perform hand hygiene thoroughly ..."	F 880		