STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING **01, 02** B. WING _____	**02/11/2020**

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
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on February 11, 2020. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the setion, 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 103 certified Medicare and Medicaid beds with a census of 88 residents. .	K 000		
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on February 11, 2020. 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 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,	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2020

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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K 000	Continued From page 1 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 103 certified Medicare and Medicaid beds with a census of 88 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 the 2012 NFPA 101, Life Safety Code. Failure to maintain means of egress as required could delay egress resulting in injury or death during an emergency. The deficiencies affected two (2) of numerous exits from the facility. The findings were: 1. Observation on 2/11/2020 at 11:27 AM at the kitchen patio revealed the means of egress was obstructed by three (3) large tables which fully blocked the exit egress. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 211	K211 1. The kitchen patio items were cleared away from the exit egress. The code panel from the main entrance has been disabled 2. Facility exits (egresses) were observed for similar concerns. Immediate actions were taken to clear or correct the exits if concerns were found. 3. Facility staff have been educated on the requirement to keep all egress access free of all obstructions to full use in case of an emergency. Observations of egress access has been added to the regular preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director or designee will complete weekly egress observations x 4	3/17/20

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K 211	Continued From page 2 of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.7.3.1; 7.1.10.1 2. Observation on 2/11/2020 at 1:33 PM at the main entrance revealed an exterior exit door that could only be opened with a code. The door had a delayed egress sign on it, but the delayed egress system had been disabled. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated he was unaware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.2.2.2.4; 7.2.1.5.3	K 211	weeks, bi-monthly observations x 4 weeks, and then monthly observations as part of the preventive maintenance program. Results of the observations will be brought 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	
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	K 222		3/17/20

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K 222	Continued From page 3 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 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	K 222		

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K 222	Continued From page 4 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could result in injury or death during an emergency. The deficiency affected one (1) of approximately four (4) exits from the secured unit. The findings were: Observation on 2/11/2020 at 12:30 PM at the secured unit dining room exit door revealed the delayed egress locking system failed to operate as designed. When tested the release process failed to activate an audible signal in the vicinity of the door as required, and failed to release the door after 15 seconds. The door could only be released by punching in a code. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.2.2.4; 7.2.1.6.1.1 (3) .	K 222	K222 1. The door to the secured unit dining room exit operates with a code. The sticker indicating otherwise was removed from the door. There is only one locking device on the door. 2. Similar doors were observed for the same concern. No other coded doors had the sticker indicating another type of lock. 3. Maintenance staff were educated on the clinical needs or security threat locking of egress doors with respect to having only one locking device on the doors. Observation and testing of these doors was added to the regular preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director or designee will complete egress door observations for locking devices x 4 weeks, bi-monthly observations x 4 weeks, and then monthly observations as part of the preventive maintenance program. Results of the observations will be brought 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	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101	K 291		3/17/20

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K 291	Continued From page 5 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide emergency lighting in accordance with the 2010 NFPA 110, Standard for Emergency and Standby Power Systems. Failure to provide emergency lighting as required could result in injury or death during an emergency. The deficiency affected less than 10 percent of the facility. The findings were: Observation on 2/11/2020 at 12:15 PM in the emergency generator transfer switch room revealed that no battery- powered emergency lighting was provided. In an emergency where the transfer switch failed to operate the battery powered emergency lighting would provide illumination at the transfer switch. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2010 NFPA 110, Section: 7.3.1	K 291	K291 1. Battery- powered emergency lighting was installed in the emergency generator transfer switch room. A 90-minute test of the emergency lighting was conducted and documented on 3/9/2020. 2. Facility areas requiring battery-powered emergency lighting were observed and lighting was tested. No other concerns were found. 3. Maintenance staff were educated on the need for emergency lighting as specified in K291. Observations and testing of this lighting is on the monthly preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director or designee will complete emergency lighting observations and monthly 90- minute tests of the emergency lights and record in the TELs system. A report of the observations will be brought 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.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		3/17/20

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K 321	Continued From page 6 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 enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiencies affected two (2) of numerous rooms in the facility. The findings were:	K 321	K321 1. The self -closing corridor door latch was repaired at the time of the survey. The activities storage room was cleared of combustible materials and a self-closure device was installed on the door. 2. Areas with hazardous area enclosures were observed for similar concerns.	

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K 321	Continued From page 7 1. Observation on 2/11/2020 at 10:33 AM in the central laundry revealed an area greater than 100 square feet. Further observation revealed a self-closing corridor door which would not fully close and latch within the door frame Interview with the facility maintenance staff at the time of observation acknowledged the door failed to close and latch, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2 2. Observation on 2/11/2020 at 10:47 AM in the activities director storage room revealed a storage room greater than 50 square feet that was filled with combustible materials, and had a rated door, but did not have a self closing device. Further observation revealed the room had a large opening in the opposite wall that was closed off with a non-rated sliding wall partition. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.3.2.1; 8.7.1.1 .	K 321	Immediate actions were taken if concerns were noted. 3. The maintenance and activities staff were educated on maintaining hazardous area enclosures and storage of combustible materials. Observations of these areas were added to the regular preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director of designee will complete weekly hazardous area enclosure observations x 4 weeks, bi-monthly observations x 4 weeks, and then monthly observations as part of the preventive maintenance program. Results of the observations will be brought 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	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		3/17/20

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K 372	Continued From page 8 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain subdivision of building spaces in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain subdivision of building spaces as required could result in fire spread resulting in injury or death. The deficiency affected one (1) of approximately nine (9) smoke/fire barriers in the facility. The findings were: Observation on 2/11/2020 at 2:20 PM above the 400 hallway in the attic area revealed an 18 inch penetration in the smoke barrier which had not been sealed. Further observation in other areas of the attic revealed no other visible unsealed penetrations in any other fire or smoke barrier. Interview with the facility maintenance manager at the time of observation acknowledged the penetration, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency.	K 372	K372 1. The penetration of the smoke barrier on above the 400 hallway was sealed. 2. Observation of all smoke barriers was completed for similar concerns. Immediate actions were taken if concerns were found. 3. The Maintenance staff were educated on the need to ensure smoke/fire barriers are intact. Observation of the 9 smoke/fire barriers in the facility was added to the regular preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director or designee will complete smoke/fire barrier observations x 4 weeks, bi-monthly observations x 4 weeks, and then monthly observations as part of the preventive maintenance program. Results of the observations will be brought to the QA committee monthly x 3 months. Problems with this process will	

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K 372	Continued From page 9 REF: 2012 NFPA 101, Sections: 8.3.4; 8.3.5 .	K 372	be brought to the QA committee for review and resolution. 5. Completion date 3/17/2020	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety Code, the 2012 NFPA 99, Health Care Facilities Code, and the 2011 NFPA 70, National Electric Code. Failure to maintain electrical systems as	K 920	K920 1. The power cord in room 312 bed #2 was removed and the electrical equipment is plugged directly into the outlet. 2. Room observations were completed	3/17/20

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K 920	Continued From page 10 required could cause a fire resulting in injury or death. The deficiencies affected one (1) of numerous rooms in the facility. The findings were: Observation on 2/11/2020 at 11:50 AM revealed resident room 312 bed #2 had patient care related electrical equipment (PCREE) plugged into a power strip located next to the resident's bed. Resident rooms with patient care related electrical equipment shall not have a power strip. Interview with the facility maintenance staff at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2012 NFPA 99, Sections: 10.2.4; 10.2.3.6 2011 NFPA 70, Section: 400-8	K 920	to ensue other power strips were not present. No other power strips were found. 3. Facility staff were educated to include no use of power strips in resident rooms. Observations of resident rooms for locating/removing power strips was added to the regular preventive maintenance schedule. 4. The Maintenance Director is responsible to monitor this process. The Maintenance Director or designee will complete room observations for locating/removing power strips x 4 weeks, bi-monthly observations x 4 weeks, and then monthly observations as part of the preventive maintenance program. Results of the observations will be brought 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	