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 08/13/2020

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 complaint survey was conducted by Healthcare Licensing and Surveys on 8/11/20 through 8/13/20. The complaint was prompted by complaint intakes WY00003048, WY00003068, and WY00003069. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted on 8/11/20. It was determined, based on the findings of the survey team, that no deficiencies were identified related to the infection control survey. The following common abbreviations are used throughout this document. BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		9/21/20

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

Electronically Signed | 09/04/2020

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, facility incident review, and policy review, the facility failed to ensure residents were free from sexual abuse for 2 of 3 residents (#2, #3) reviewed. The findings were: Review of the 7/29/20 quarterly MDS assessment showed resident #1 had diagnoses which included altered mental status, cerebral infarct, and cerebral vascular disease. The resident had a BIMS score of 5, indicating severe cognitive impairment. Review of the resident's care plan showed a plan dated 3/20/20 regarding sexually inappropriate behavior. The initial plan interventions included "Close observation when in common areas near [male/female] residents-redirect if closer than arm's length away," and "Identify physical or verbally inappropriate behavior (e.g. 'You are touching me' and 'You are standing too close')." The following concerns were identified: 1. Review of a facility reported incident that occurred on 3/19/20 showed CNA #3 witnessed resident #1 walking up to another resident (resident #2) who was sitting in the common area. Resident #1 approached the second resident from behind, bent over and slid his/her left hand into the second resident's pants while sliding his/her right hand under the second resident's shirt and grabbing the resident's left breast. At the time of the incident resident #2 was sleeping. The CNA reported this observation to RN #1, who	F 600	1. Resident□s #1, #2, and #3 were assessed at the time of the cited events and their care plans updated. The IDT reviewed the care plans for these residents again and made appropriate updates as needed. Staff were re-educated on the care plan for resident #1. 2. The facility has and will continue to conduct thorough investigations when resident to resident altercations occur. Residents of the dementia unit were questioned again to see if they feel safe in the facility and to determine whether there are any concerns with treatment by others. 3. Staff who failed to report at the time the cited event occurred received counseling and written disciplinary action. Staff of the facility were re-educated on the requirement for timely reporting of abuse to the Administrator. Staff of the facility were also re-educated on abuse prevention and investigation. 4. The Administrator is responsible for abuse prevention and investigation. The Administrator will bring any abuse investigations to the QA committee monthly x 3 months for review to ensure all necessary steps were taken to protect residents and meet the regulatory and timeliness requirements. Problems identified by the QA committee will be	

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F 600	Continued From page 2 documented the incident in nursing progress notes, but did not report the incident to facility administration. The facility's investigation further concluded sexual abuse had occurred. Review of the 5/10/20 significant change MDS assessment showed resident #2 had diagnoses that included dementia and major depressive disorder, and a BIMS score of 2 (severe cognitive impairment). Both residents resided on the dementia unit. Further review of the facility incident report showed neither resident recalled the incident afterward. 2. Review of a facility reported an incident that occurred on 4/29/20 showed resident #1 was in the sunroom of the dementia unit and staff were in an adjacent common area. Resident #3 approached resident #1, and resident #1 asked him/her if s/he "wanted to play." Resident #3 replied, "No." Then resident #1 rubbed his/her hands on resident #3's breasts over his/her shirt, and began to reach inside the shirt. Resident #3 left and reported the behavior to facility staff. Resident #3 accurately described resident #1 as the perpetrator and stated s/he was fearful. The facility's investigation concluded sexual abuse had occurred. Review of the 5/19/20 quarterly MDS assessment showed resident #3 had a BIMS score of 11 (indicating moderate cognitive impairment). Review of the medical record showed no indication of a change in the resident's behavior. 3. Interview with the administrator on 8/11/20 at 5 PM revealed CNA #3 and RN #1 were no longer employed by the facility. The administrator confirmed the events of 3/19/20 and 4/29/20 occurred as described in the facility reports.	F 600	corrected immediately. 5. Completion date: 9/21/2020	

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F 600	Continued From page 3 4. Review of the staff education sign-in dated 7/3/20 showed staff read and signed the following: "Regarding [resident #1] in [resident's room number] [s/he] must be a 1 on 1 care at all times. This 1 on 1 caregiver cannot do any other duties. [The resident] has to have 1 staff with [him/her] at all times." 5. Review of the facility's undated policy titled "Abuse Policy" showed "Each resident shall be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion ...In instances of potential abuse, the facility shall employ procedures for immediate identification and investigation of the possible abuse, while protecting the resident(s); and shall report all finding in accordance with state and federal laws, requirements, and/or regulations."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		9/21/20

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F 609	Continued From page 4 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, facility reported incident review, and policy review, the facility failed to report allegations of abuse to the State Survey Agency in a timely manner for 2 of 4 incidents reviewed (incidents involving residents #1, #2, an #3). The findings were: 1. Review of a facility report of an incident that occurred on 3/19/20 showed resident #1 approached resident #2 from behind and slid his/her hands under the resident's clothing and "grabbed" his/her breast. The incident was witnessed by CNA #3 and reported to RN #1, who documented an incident in progress notes, but failed to notify the facility administration of the incident. The incident was discovered the next day by routine quality review of nursing progress notes. Review of the State Survey Agency incident reporting logs showed the incident was initially reported to the agency on 3/20/20. 2. Review of a facility report of an incident that occurred on 4/29/20 showed resident #1 asked resident #3 if s/he "wanted to play." Resident #3 responded, "No" and resident #1 proceeded to	F 609	1. Resident□s #1, #2, and #3 were assessed at the time of the cited events and their care plans updated. 2. Residents of the dementia unit were questioned to see if they feel safe in the facility and to determine whether there are any concerns or previously unreported events that require a report to the State Survey Agency. No other concerns were identified. 3. Staff who failed to report at the time the cited event occurred received counseling and written disciplinary action. Staff of the facility were re-educated on the requirement for timely reporting of abuse to the Administrator. The facility has identified two additional staff members who will obtain access to the portal for state reporting of incidents to facilitate timely reporting. 4. The Administrator is responsible for abuse reporting. The Administrator will bring any abuse reports/investigations to the QA committee monthly x 3 months for review to ensure all necessary steps were	

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F 609	Continued From page 5 rub his/her hands over resident #3's breast over his/her shirt, and began to reach inside the resident's shirt. Resident #3 left and reported the incident to facility staff. Review of the State Survey Agency incident reporting logs showed the incident was initially reported to the agency on 5/6/20 (7 days later). 3. Interview with the administrator on 8/11/20 at 5 PM confirmed both incidents were reported to the State Survey Agency late and should have been reported within two hours after the allegation of abuse is made. 4. Review of the undated facility policy titled, "Abuse Policy" showed " ...Each resident shall be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion ...In instances of potential abuse, the facility shall employ procedures for immediate identification and investigation of the possible abuse, while protecting the resident(s); and shall report all findings in accordance with state and federal laws, requirements, and/or regulations."	F 609	taken to protect residents and meet the state requirement for timeliness. Problems identified by the QA committee will be corrected immediately. 5. Completion date: 9/21/2020	