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 _____	10/08/2020

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
E 000	Initial Comments A COVID-19 focused infection prevention survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 10/6/20 to 10/8/20. It was determined, based upon the findings of the survey team, that a deficiency was identified pertaining to the infection control survey. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant Less commonly used abbreviations will be annotated in each deficiency.	E 000		
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,	F 880		11/11/20

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

Electronically Signed | 11/02/2020

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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F 880	Continued From page 1 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 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.	F 880		

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F 880	Continued From page 2 §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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review and review of the Center for Disease Control (CDC) guidelines, the facility failed to ensure residents and staff utilized appropriate personal protective equipment on 1 of 4 units (300 unit), additionally failed to ensure social distancing on 1 of 4 units (500 unit) to prevent the spread of COVID-19. The findings were: 1. Observation on 10/6/20 at 12 PM to 12:25 PM showed the secure unit dining room was arranged with 2 rows of tables and 4 tables in each row. Further observation showed residents were only seated at tables in the row closest to the fire place. The following concerns were identified: a. Observation on 10/6/20 at 12 PM showed table #1, which was closest to the food preparation area, had 2 residents at the table. 1 resident was positioned at the 3 o'clock position and the other was positioned across the table at the 9 o'clock position. Further observation showed table #2 had one resident seated at the 6 o'clock position. The resident at table #1 seated at the 3 o'clock position was not positioned more than 6 feet from the other resident at table #1 or	F 880	1. Resident #1 no longer resides at the facility. Resident #2 has not had any adverse effect and has not tested positive for Covid-19 weekly x 3 cycles. Residents throughout the facility have tested negative x 3 weekly cycles. 2. Residents without a previous positive Covid-19 test are tested weekly and remain negative. There have not been new cases since the initial outbreak. The facility IDT and QA committee are reviewing the facility's current infection control policies for social distancing in communal areas, and mask procedures for all departments. 3. The dining tables in the dementia unit were moved to provide a 6ft distance between residents when dining. The tables were marked on the top to indicate where residents can and cannot be placed. Each table now will have only one resident per table except at tables large enough to allow a 6ft distance between the residents. Residents are being encouraged often to wear masks when in common areas. Staff were educated on the 6ft requirement for social	

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F 880	Continued From page 3 the resident at table #2 and the residents were not wearing face masks. b. Observation on 10/6/20 at 12 PM showed table #3 had a resident seated at 12 o'clock position and a resident seated across the table at the 6 o'clock position and the residents were not wearing face masks. c. Observation on 10/6/20 at 12:20 PM showed resident #1 was assisted to the 4th table and positioned at the 12 o'clock position, across from another resident. Resident #1 was wearing a mask; however, the other resident was not. Staff placed a tray in front of resident #1. Review of a progress note dated 9/25/20 and timed 4:32 PM showed resident #1 was transferred to the COVID unit following a positive COVID test result. d. Interview with the infection preventionist on 10/6/20 at 1:55 PM revealed residents should not be placed at the same table if the table is not 6 feet across and they should be positioned to allow 6 foot of social distancing. Further interview revealed resident #1 had recently returned to the 500 unit from the COVID unit. e. Interview with the administrator on 10/6/20 at 2:16 PM revealed she believed the dining tables in the 500 unit measured 48 inches (4 feet) across. 2. Observation on 10/6/20 at 11:15 AM showed CNA #1 entered room 301 and closed the door. The CNA was wearing a cloth face mask. 3. Observation on 10/6/20 at 11:17 AM showed CNA #2 exited room 305 with a bag of soiled items which she discarded, and then washed her hands. The CNA was wearing a cloth face mask.	F 880	distancing including meals and the use of procedure masks instead of cloth masks for direct care staff. 4. The Administrator and/or designee is monitoring the communal dining process for social distancing in the dementia unit and mask usage in the facility. Observations of social distancing and mask usage will be conducted biweekly x 12 weeks and then monthly x 3 months. Observations and monitoring will be reported to the QA committee monthly and continue until the QA committee determines sustained compliance has occurred. 5. Compliance date: November 11, 2020.	

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F 880	Continued From page 4 4. Interview with the infection preventionist on 10/6/20 at 1:55 PM revealed all direct care staff should wear approved personal protective equipment (PPE). Further interview revealed cloth face masks were not approved PPE for direct care staff. 5. Review of the CDC Guidance titled "Preparing for COVID-19 in Nursing Homes" updated 6/25/20 showed "...Implement Source Control Measures. HCP [Healthcare Personnel] should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required..."	F 880		