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 01/19/2021

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 from 1/13/21 through 1/19/21. The survey was prompted by complaint intakes WY00003187 and WY00003180. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys from 1/13/21 through 1/19/21. The following common abbreviations are used throughout this document; ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 564 SS=G	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.	F 564		3/17/21

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

Electronically Signed | 02/11/2021

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F 564	Continued From page 1 (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident representative interview, staff interview, and policy and procedure review, the facility failed to ensure residents received or were offered compassionate care visits during a facility outbreak of COVID-19 for 3 of 11 sample residents (#66, #71, #72) reviewed with a change of condition. This failure resulted in harm to residents #71 and #72, who died without receiving a visit with family. The findings were: 1. Review of the medical record for resident #72 showed the resident had diagnoses which included age-related osteoporosis with a current fracture of the right humerus, stage 3 coccyx pressure ulcer, diabetes mellitus, and flaccid hemiplegia affecting the left non-dominant side. Review of the 11/20/20 significant change MDS assessment showed the resident had a BIMS score of 6/15 (cognitively impaired), required extensive assistance for all ADLs except for bathing and transfers which required the total	F 564	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied. F564 1. Residents #66, #71, and #72 no longer reside at the facility. 2. Visitation rights may affect all residents and/or resident representatives.	

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F 564	Continued From page 2 assistance of two staff members, and did not require supplemental oxygen. The following concerns were identified: a. Review of a progress note dated 12/26/20 (Saturday) and timed 8:41 PM showed "resident observed to have a dry mouth and deep shallow breathing. All medications held this HS [bedtime] due to resident change in status." Further review showed the resident's oxygen saturation level fell to 85% and 2 liters of oxygen was applied. There was no evidence the physician or resident's representative were notified of the change of condition. b. Review of the December 2020 medication administration record showed the resident refused his/her medications on 12/27/20 (Sunday). A corresponding nurse's note stated the resident was unable to open his/her mouth and swallow the medication. There was no evidence the physician or resident's representative were notified of the change of condition. c. Review of a progress note dated 12/28/20 and timed 1:45 PM showed " ...less responsive, stares at the wall, does not smile, does not talk, does not open mouth for food or pills ..." A progress note timed 3:59 PM showed the resident's family and the physician were notified and the resident was placed on comfort care. Further review showed the resident expired on 12/29/20 at 3:35 AM. d. Interview with the DON on 1/13/21 at 4 PM revealed she had not anticipated the resident's death to occur so quickly and had set up a compassionate care visit for 12/29/20. In an additional interview on 1/15/21 at 10:46 AM the DON stated she was unaware of the resident's change of condition until 12/28/20 (Monday) when she came to work (2 days after the change of	F 564	A letter was written to residents and/or resident representatives to inform them of the current facility policy and procedures regarding visitation rights, following current CMS guidance on visitations, including compassionate care visitation. 3. The facility will contact current residents (or resident representative, where appropriate) with current facility policy and procedures regarding visitation rights, including compassionate care visitation, to ensure each resident is aware of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, the reasons for the restriction or limitation, and to whom the restrictions apply. The method of communication will include but not be limited to letters, website postings, telephone calls, emails, and verbally in-person. The facility will record to whom and by what means the information was provided. Staff will be educated on the facility policy for visitation including compassionate care visitation and the current CMS guidance on visitations. 4. Notice of change in relevant CMS visitation guidance, or facility policy or procedure, will be documented and method of communication will be recorded. This log will be audited by the Administrator or designee to ensure ongoing compliance. The administrator or designee will report results of the audits at the QA meetings. The report will include any problems identified. Reporting will	

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F 564	Continued From page 3 condition was first noted). e. Interview with the resident's representative on 1/15/21 at 8:53 AM revealed the last time she saw the resident in person was 11/17/20 during a physician office visit outside of the facility. Further, she had FaceTime visits weekly with the resident, but felt the facility should have known the resident was declining longer than the 12 hours notice she received before the resident died. 2. Review of the medical record for resident #71 showed the resident had diagnoses which included cellulitis and diabetic ulcer of the right foot with intravenous antibiotics, diabetes mellitus, hemiplegia, chronic kidney disease stage 3, and an acquired absence of the left foot. The resident was receiving intravenous antibiotics for treatment of a methicillin-resistant Staphylococcus aureus infection. Further review showed the resident had been transferred to a geriatric psychiatric hospital from 10/24/20 through 10/27/20 for behaviors. Review of the 11/2/20 significant change MDS assessment showed the resident had a BIMS score of 12/15 (moderate cognitive impairment) and was coded as being independent with eating. The following concerns were identified: a. Review of a nurse's progress note dated 11/11/20 showed the resident's representative was notified the resident's foot was not healing, was becoming more necrotic, and the resident had seen an orthopedic surgeon. The surgeon had recommended "amputation at this time after MRI [magnetic resonance imaging] to determine how far up the infection has gone and if osteomyelitis is present." b. Review of an IDT (interdisciplinary team) progress note dated 11/11/20 showed the	F 564	occur no less than three months or until ongoing compliance has been achieved. 5. Completion date: 3/17/2021	

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resident had lost 7 pounds and "Not doing well related to infection, surgical candidate at this time after seeing surgeon. Resident is not eating well. Resident gets milkshake with juven [a nutritional supplement]." Review of a skilled nursing evaluation dated 11/16/20 showed "Resident needs assistance with eating."

c. Review of an IDT progress note dated 11/19/20 showed " ...Behaviors have declined, but resident is notably ill ..." There was no evidence the physician or resident's representative was notified of the change of condition.

d. Review of a nurse's note dated 11/21/20 showed the resident expired at 3:15 AM. The resident's representative was notified at 3:20 AM and "was devastated and wanted to know what the cause of death was ..."

e. Interview with the resident's representative on 1/15/21 at 11:23 AM revealed the resident's death was "kind of unexpected". In addition, the representative stated he had last seen the resident in person in October of 2020 related to some behavioral problems and had not been contacted by the facility since that time related to a compassionate care visit.

f. Interview with the DON on 1/15/21 at 10:46 AM revealed the resident's decline should have been discussed during the IDT meeting, however the facility was focused on moving ahead with the resident's surgery. Further, the DON stated the resident's representative had been notified of the surgeon's recommendations, but not the resident's decline.

g. Interview with the NHA on 1/19/21 at 11:16 AM revealed there was a lot of COVID-19 in the building at the time of the resident's decline and death, so the facility "could not bring the family members inside and the resident was too sick to be moved."

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F 564	Continued From page 5	F 564		

3. Review of the 11/15/20 quarterly MDS assessment for resident #66 showed the resident had diagnoses which included debility, cardiorespiratory conditions, COVID-19, and non-Alzheimer's dementia. The resident had a BIMS score of 3/15 (severe cognitive impairment). Review of the medical record showed the resident tested positive for COVID-19 on 11/9/20 and was moved out of quarantine on 11/19/20. The following concerns were identified:

a. Review of nurses' progress notes from 11/19/20 and 11/21/20 showed the resident was refusing care, was withdrawn, and had mottled skin throughout and was cool to the touch.

b. Review of a progress note dated 11/21/20 and timed 9:30 AM showed "talked to [social services] about resident's decline and comfort cares ...family will come visit."

c. Review of a nurse's note dated 11/24/20 showed the resident expired at 11:48 AM.

d. Interview with the resident's representative on 1/15/21 at 9:15 AM revealed RN #1 had called to inform him of the resident's decline, however the facility did not offer a compassionate care visit. Further, he stated he called the facility to initiate the compassionate care visit for his family which occurred on 11/22/20.

4.Interview with the director of social services on 1/13/21 at 1:03 PM revealed a determination of the necessity of compassionate care visits was supposed to be made by the IDT and families were typically granted 2 hour time slots with some exceptions if a resident was actively dying.

5. Interview with RN #1 on 1/13/21 at 3 PM revealed compassionate care visits were scheduled through the social services

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F 564	Continued From page 6 department, visitors were screened in through the 400 hallway entrance, and limited to 2 hours. 6. Interview with the DON on 1/15/21 at 10:46 AM revealed compassionate care visits were determined on a case-by-case basis. Staff members would inform her if they thought a compassionate care visit was warranted and she would make a decision. The nurses would then arrange for the visit. 7. Review of an undated policy and procedure entitled "Limited COVID-19 Indoor Visitation Policy and Procedure" showed " ...Goshen Healthcare Community acknowledges that it is equally important to consider the quality of life and dignity (sic) our residents, and the critical role of family relationships to overall health. During the pandemic, visitation is permitted for compassionate care until we reach certain parameters as described by governmental guidelines for broader visitation allowance. At Goshen Healthcare Community, we will define it as allowing in-person visitation for patients for whom prognosis is terminal with a short life expectancy, as well as other extenuating circumstances affecting resident quality of life on a one-to-one basis. All visitation must be cleared with the management team. EG. Administrator, DON, Social Services Director, Medical Director or MD/PA of record who confirm that the resident is terminal or falls under the term compassionate care."	F 564		
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;	F 580		2/23/21

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F 580	Continued From page 7 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 §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	F 580		

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F 580	Continued From page 8 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, staff and resident representative interview, and policy and procedure review, the facility failed to ensure the physician and the resident's representative were notified for 1 of 5 sample residents (#72) reviewed for change of condition. The findings were: 1. Review of the medical record for resident #72 showed the resident had diagnoses which included age-related osteoporosis with a current fracture of the right humerus, stage 3 coccyx pressure ulcer, diabetes mellitus, and flaccid hemiplegia affecting the left non-dominant side. Review of the 11/20/20 significant change MDS assessment showed the resident had a BIMS score of 6/15 (cognitively impaired), required extensive assistance for all ADLs except for bathing and transfers which required the total assistance of two staff members, and did not require supplemental oxygen. The following concerns were identified: a. Review of a progress note dated 12/26/20 and timed 8:41 PM showed "resident observed to have a dry mouth and deep shallow breathing. All medications held this HS [bedtime] due to resident change in status." Further review showed the resident's oxygen saturation level fell to 85% and 2 liters of oxygen was applied. There was no evidence the physician or resident's	F 580	1. Residents #71 and #72 no longer reside at the facility. 2. The interdisciplinary team conducted a review of resident medical records to identify any change of conditions warranting notification. Two residents were identified and families were contacted to discuss the change. 3. Nursing staff were educated on the facility policy for Change of Condition or Status and notification of physician and family. 4. The Director of Nursing (DON) is responsible for monitoring resident change in condition and notification of physician and family. The DON or designee will perform ongoing medical record reviews for change in condition and appropriate notification of physician and family. The IDT will conduct weekly audits of change in condition and notification x 90 days. Any concerns or discrepancies will result in immediate education and corrective action. The DON or designee will report the results of the audits to the QAPI committee. The report will include any problems identified. Reporting will occur no less than three months or until ongoing compliance has been achieved.	

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F 580	Continued From page 9 representative were notified of the change of condition. b. Review of the December 2020 medication administration record showed the resident refused his/her medications on 12/27/20. A corresponding nurse's note stated the resident was unable to open his/her mouth and swallow the medication. There was no evidence the physician or resident's representative were notified of the change of condition.	F 580	5. Completion date: February 23, 2021	