PRINTED: 02/07/2006
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN CARE CENTER	2009 LARAMIE STREET TORRINGTON, WY 82240

2/28/06

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 Surveyor #: 18185 The regulatory reference is 42 CFR 483.70 (a) except where a different regulation may be specifically referenced. K3: Building: Type V (111) single story building with a 2-hour separation from Community Hospital and equipped with a complete supervised automatic wet sprinkler system with a dry branch in the attic. K6: Date of Plan Approval: 1996 K7: Life Safety Code surveyed under 2000 Existing Health Care K8: Total Beds=75;NF=75 K9: The facility meets the Life Safety Code standards based on an acceptance of a plan of corrections "NFPA" National Fire Protection Association	K 000	POC WAS ACCEPTED WITH GORDON LEWIS, CEO, 02/28/06 @ 1:30PM VIA TELECONFERENCE. Acceptance	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3,6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	(1) Plan of correction: install smoke seal on the rooms listed below: (a) 201-install smoke seal (b) 209-install smoke seal (c) 211-install smoke seal (d) 306-install smoke seal (e) 402-install smoke seal. Plan to be completed by 3/11/06. To avoid deficiency in the future this issue will be monitored by the maintenance department on a preventative maintenance basis. (2) Plan of correction: install smoke seal to the edges of doors. Plan to be completed by 3/11/06. To avoid deficiency in the future this issue will be monitored by the maintenance department on a preventative maintenance basis. OK	3-11-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: Feb 21, 2006

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 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations on 01/23/06, the facility failed to protect the corridor system in accordance with NFPA 101 Section 19.3.6.3. The findings were: 1. Observation on 1/23/06 between 11:42 AM and 12:37 PM revealed the following resident rooms had gaps between the top edge of their corridor doors and door frames which were greater than the allowed. a. Resident room #201. b. Resident room #209. c. Resident room #211. d. Resident room #306. e. Resident room #402. 2. Observation on 1/23/06 at 11:00 AM revealed the edges of the marketing office double doors had a gap greater than the allowed 1/8 inch.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	(1) Plan of correction: remove bucket of cleaning supplies. Plan completed immediately. To avoid this deficiency in the future the staff will be educated on these types of safety issues. (2) Plan of correction: install automatic magnets, (connected to the fire alarm system);	

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K 029	Continued From page 2 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to separate 2 of 12 hazardous areas from other spaces by smoke-resistant doors in accordance with NFPA 101 Section 19.3.2.1. The findings were: 1. Observation on 1/23/06 at 11:17 AM revealed the laundry clean room corridor door had a self-closing device and was blocked open by a bucket of cleaning supplies. 2. Observation on 1/23/06 at 11:26 AM revealed the laundry room corridor door had a self-closing device was impeded by a service cart.	K 029	on doors to avoid being propped open. Plan to be completed by 3/11/06. To avoid this deficiency in the future the automatic magnets will keep the doors open until the fire alarm is triggered. 3-11-06 Acknowledging the need for plan review by the state Department of Health for connecting the magnetic door closer to the fire alarm system we are planning on establishing the following milestones in the timeframes contemplated: • Development and submittal of plan for state review by March 11, 2006. • Return of approved plan from state by April 11, 2006. • Completion of project by May 25, 2006.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation the facility failed to test and maintain the installed sprinkler system in accordance with NFPA 13 Section 1-4.6. The finding was: 1. Observation on 1/23/06 at 11:07 AM revealed the sprinkler head in the janitors' closet in the	K 062	(1) Plan of correction: install smooth continuous ceiling. Plan to be completed by 3/11/06. Better inspections will done in the future to avoid this deficiency. 3-11-06	

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K 062	Continued From page 3 "link" was not installed under a smooth continuous ceiling as required by the Code. The ceiling tile above the electrical breaker box had a large unsealed penetration.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 . This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain and test 1 of 15 portable fire extinguishers in accordance with NFPA 10 Table 5-2. The finding was. 1. Observation on 1/23/05 at 3:19 PM revealed the K-type portable fire extinguisher in the kitchen was manufactured in 1999 and had not received a five year hydrostatic test as required by the Code.	K 064	(1) Plan of correction: the K-type portable fire extinguisher in the kitchen received a five year hydrostatic test on 1-28-06. To avoid this deficiency in the future the fire extinguisher inspection company was informed that this equipment will require inspection every five years. This issue will also be monitored by the maintenance department on a preventative maintenance basis. 3-11-06	