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 _____	11/04/2021

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 recertification survey was conducted by Healthcare Licensing and Surveys from 11/1/21 to 11/4/21. The following abbreviations were used throughout the document: DON: Director of Nursing MDS: Minimun Data Set	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to accurately document active diagnoses for 1 of 16 residents (#8) reviewed. The findings were: 1. Review of the 8/11/21 quarterly MDS assessment showed resident #8 had diagnoses which included Alzheimer's disease, cognitive communication deficit, tachycardia, pulmonary embolism and pneumonia. Observation on 11/2/21 at 10:21 AM showed the resident ambulating in the hallway. Review of the physician orders did not show orders for antibiotics. The following concerns were identified: a. Interview on 11/3/21 at 10:03 AM with the infection prevention nurse revealed he kept monthly logs of residents who had infections, and the logs showed the resident did not have pneumonia in August.	F 641	F641 Corrective action: The MDS for resident #8 was modified to correct the error and re-submitted to CMS. Identification of other residents: Resident records with similar acute conditions were identified and reviewed for errors. Errors were corrected as indicated. Systemic Changes: Re-education was done with the MDS Coordinator. During quarterly review of MDS, the IDT team will review diagnoses for accuracy. Monitoring: The Administrator or Designee will complete a monthly audit of resident diagnosis on completed MDS assessments for each month to ensure acute conditions are reflective of current conditions for each resident reviewed. These audits will be completed for no less	12/9/21

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

Electronically Signed | 11/29/2021

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F 641	Continued From page 1 b.. Interview on 11/3/21 at 3:33 PM with the MDS coordinator, stated the resident had COVID, a pulmonary embolism, and pneumonia earlier in the year, but those had resolved. She stated the resident did not have pneumonia when the quarterly MDS was completed in August and the diagnosis of pneumonia was an error. She stated she would submit a modification to the MDS.	F 641	than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the Administrator or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 12/9/2021	
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		12/9/21

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F 732	Continued From page 2 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of posted nurse staffing data, and staff interview, the facility failed to ensure the posted 24-hour nursing staff information was maintained and updated to reflect the actual hours worked for 15 of 15 days (10/19/21 through 11/2/21) reviewed. The census was 61. The findings were: Review of the posted 24-hour nurse staffing data from 10/19/21 through 11/2/21 failed to show the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses, and certified nurse aides responsible for resident care per shift. Interview on 11/3/21 at 2:49 PM with the DON confirmed the posted 24-hour nurse staffing information failed to include the actual hours worked.	F 732	F732 Corrective action: The DON corrected the deficiency by updating the staffing board to reflect the correct number of RN, LPN, Med Aide and CNA staff actual hours worked for the days of 10/19/21 through 11/2/21. Identification of other residents: All residents have the potential to be affected by the posting of nursing staff actual hours worked. Systemic Changes: Nursing staff will be re-educated on the process to ensure continuity of documentation. The posted nurse staffing information will be audited daily by the DON or designee to ensure the 24 hour nurse staffing information reflects the current number of staff and hours worked. The DON or designee will identify call offs, staff present, and will update staffing information throughout the day if staff ratios change. Monitoring: The Administrator or designee will conduct weekly audits of posted staff	

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F 732	Continued From page 3	F 732	information for accuracy for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the Administrator or designee until compliance is achieved. The system will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 12/9/2021	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		12/9/21

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F 801	Continued From page 4	F 801		

recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant

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F 801	Continued From page 5 management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on review of employee education, review of employee files, and staff interview the facility failed to ensure the director of the dietary department held certifications or education to meet the requirements. The census was 61. The findings were: Interview with the dietary director on 11/01/21 at 10:41 AM revealed in an attempt to meet qualifications she and the assistant manager had recently completed a "ServeSafe" food safety course. However, neither were certified as a foodservice manager or a dietary manager. Review of the employee file showed the dietary director had been in the director position starting in June 2018, and took a step down to work as a cook in November 2019. She had recently accepted the director position again on April 16, 2020. Review of the 11/3/21 receipt of payment showed the director was enrolled to take a qualifying Certified Food Service Manager Course and exam from the International Food Service Executives Association (IFSEA).	F 801	F801 Corrective action: The Dietary Manager enrolled in CMS approved course and completed and passed the exam on November 12, 2021. Identification of other residents: All residents have the potential to be affected by the qualifications of the dietary manager. Systemic changes: The passing of the exam will be audited for completion. A list of approved educational pathways will be incorporated into the job description for the Dietary Manager position. Monitoring: The Administrator is responsible for monitoring the exam completion. Documentation of exam completion will require a one time audit. Exam completion will reviewed in QA. Compliance Date: 12/9/21	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		12/9/21

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F 812	Continued From page 6 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility education information, the facility failed to ensure proper handwashing was performed during 1 of 1 meal service observations (the noon meal on 11/3/21). The findings were: Observation on 11/3/21 at 11:40 AM showed the food was delivered to the secure unit kitchen and serving area. The cook who was preparing to serve the meal was cook #1. The following concerns were identified related to hand hygiene: a. At 11:47 AM cook #1 washed her hands and donned gloves. She then handled the door to the beverage refrigerator, and the door handle to the door leading from the kitchen to the serving area. She failed to remove the gloves and	F 812	F812 Corrective action: One on one education done with cook #1 and review of hand hygiene policy and procedure completed. Identification of other residents: All residents have the potential to be affected by hygiene performance of dietary staff. Systemic changes and Monitoring: Dietary staff in-service and education will be done with all dietary staff by the Dietary Manager or designee to review hand hygiene policy and procedure on or by the date of compliance. The Dietary Manager or designee will conduct weekly random audits of hand hygiene and glove use to	

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F 812	Continued From page 7 perform hand hygiene prior to filling beverage cups. b. At 11:52 AM she removed the gloves and washed her hands. Donning new gloves, she then handled the refrigerator door to get the milk. She then handled the cups to fill them without removing the gloves. c. At 11:57 AM she handled the door handle with bare hands to open the door from the kitchen into the serving area and then put on gloves without hand hygiene to complete filling the beverage cups with juice. d. Interview with the dietary manager on 11/4/21 at 1 PM confirmed door handles would be considered dirty and hand hygiene and new gloves would be needed. She further stated the door from the kitchen into the serving area was usually propped open during the meal service. e. Review of the 10/8/21 food service education document on glove use showed cook #1 was in attendance. The instructions included "...To avoid cross-contamination, change gloves when you change activity; wash hands in between." Further, it showed the need to wash hands "After handling soiled equipment or utensils, money, handling garbage, or using the phone." f. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: "... (E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves to initiate a task that involves working with FOOD; and (I)	F 812	identify any deviations from policy and procedure for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the Dietary Manager or designee until compliance is achieved. Systems will be reviewed for quality assurance. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 12/9/21	

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F 812	Continued From page 8 After engaging in other activities that contaminate the hands."	F 812		
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, 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;	F 880		12/9/21

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F 880	Continued From page 9 (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. §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, and policy and procedure review, the facility failed to ensure infection prevention practices were followed for 1 of 1 observation of wound care (resident # 25). The findings were: 1. Observation on 11/3/21 at 1:49 PM showed the	F 880	F880 Corrective Action: The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements identified in the deficiency. The nurse providing wound care was re-educated on date of	

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F 880	Continued From page 10 DON performed wound care on resident #25. The DON donned gloves, and removed the dressing on the resident's coccyx area. The DON cleansed the wound using Skintegrity spray and gauze dressing. While wearing the same gloves, the DON touched the clean bottle of Therahoney and applied the substance to a clean cotton tipped applicator, then applied to the wound. The DON proceeded to put a piece of Silver alginate on the wound then covered with a clean dressing. After completing the wound care the DON pulled the resident's pants up and removed her gloves. She put the supplies back in the wound supply box, then touched the curtains and bed control. As she left the resident's room, she used hand sanitizer. a. Interview with the DON on 11/3/21 at 1:49 PM confirmed she did not remove her gloves nor perform hand hygiene after removing the dressing and performing clean wound care. b. Review of the Dressings Clean/Aseptic policy, with a revision date 8/21 showed "...Procedures...10. Put on clean gloves. Loosen tape and remove soiled dressings...11. Remove gloves and discard in plastic or biohazard bag with dressing. 13. Wash hands or use alcohol gel....14. Put on clean gloves...21. Apply the ordered dressing...22. Remove gloves and discard in bag...23. Wash hands..."	F 880	concern after concern was identified. Nursing Staff with wound care as part of their scope of practice will be educated by the Infection Preventionist or designee on or by the date of compliance on wound care procedures as related to infection control. Identification: All residents at the facility have the potential risk for wounds which would require wound care that meets standards of practice for infection control. Systemic Changes: On or before 11/30/21 the facility will complete root-cause analysis to identify and address reasons for non-compliance related to wound care procedures. On or prior to the date of compliance the Infection Preventionist or Designee will ensure nursing staff with wound care as part of their scope of practice is educated regarding wound care policy and procedures. Appropriate nursing staff will be educated during onboarding, yearly and as needed. Also, recommendations from DPOC concerning hand hygiene and QIO involvement will be incorporated into general education of all staff. Monitoring: The Infection Preventionist or designee will conduct weekly random audits of wound care procedures to identify any deviations from wound care policy and procedure for no less than 12 weeks to ensure compliance. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits will be reported at the QA&A meeting by the Infection Preventionist or designee until compliance is achieved. The QAPI	

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F 880	Continued From page 11	F 880	committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 12/9/2021	