| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535057 | A. BUILDING **01, 02**<br>B. WING _____ | **11/02/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **GOSHEN HEALTHCARE COMMUNITY** | **2009 LARAMIE STREET**<br>**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 |
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| E 000 | Initial Comments<br><br>An emergency preparedness survey was conducted by healthcare Licensing and Surveys on April 6, 2021.<br><br>Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on November 2, 2021.<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the setion, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association.<br><br>The facility was a fully sprinklered, single story building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the alzheimer building (SCU). The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 63 residents.<br>. | K 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on November 2, 2021. | K 000 | | |

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

Electronically Signed | 11/29/2021

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 000 | Continued From page 1<br>Requirements for Long Term Care Facilities<br>Section 42 CFR 483.70 (a) except as otherwise provided in the setion, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association.<br><br>The facility was a fully sprinklered, single story building of Type V (111) construction built in 2008. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the main building (NH). The facility had a capacity of 103 certified Medicare and Medicaid beds with a census of 63 residents.<br>. | K 000 | | |
| K 211 SS=D | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress doors as required could delay egress resulting in injury or death during an emergency. The deficiency affected two (2) of numerous doors in the facility. The findings were: | K 211 | K211<br><br>Corrective Actions: The doors to the exit by the mechanical and laundry rooms was repaired to reduce the force required to open the door. To reduce the amount of force, the weather stripping was changed.<br>Identification of Others: Potentially all residents and staff could be affected by a | 11/29/21 |

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| K 211 | Continued From page 2<br>Observation on 11/2/2021 at 10:38 AM at the doors leading to the exit by the mechanical and laundry rooms revealed that the left leaf exceeded thirty (30) pounds of force to open.<br><br>Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101: Section 19.2.2.2.1, 7.2.1.4.5<br>. | K 211 | door that was not easy to open in an emergency.<br>Systemic Changes: The Maintenance staff were educated on the need for exit doors to open with minimal exertion during an emergency. All exit doors have been added to the TELS Preventive Maintenance (PM) schedule to ensure that they open easily with minimum pressure. Exit doors will be inspected monthly on an ongoing basis. Any problem with any exit doors will require immediate repair.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br><br>Compliance date: 11/29/2021 | |
| K 223 SS=D | Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous | K 223 | | 11/29/21 |

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| K 223 | Continued From page 3<br>area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide a self-closing door that latched in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide a latching and self-closing door as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of numerous doors in the facility. The findings were:<br><br>Observation on 11/2/2021 at 11:10 AM at the clean utility room on the 400 wing, revealed that the door failed to latch when it was released from a fully open position.<br><br>Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101: Section 7.2.1.8.2<br>. | K 223 | K223<br>Corrective Actions: The clean utility room door on the 400 wing was repaired.<br>Identification of Others: Potentially all residents and staff can be affected by delaying egress in an emergency.<br>Systemic Changes: The Maintenance staff were educated on the need for self-closures that close and latch properly. Self-closing doors were added to the TELS Preventive Maintenance (PM) system to be inspected monthly on an ongoing basis. Any problems with doors that have self-closures will be require immediate repair.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations and corrective | |

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| K 223 | Continued From page 4 | K 223 | action. Results of the audits will be reported at the QA&A meeting by the Administrator or designee until compliance is achieved. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br><br>Compliance date: 11/29/2021 | |
| K 293 SS=D | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death. The deficiency affected three (3) of numerous corridors in the facility. The findings were:<br><br>Observation on 11/2/2021 at 10:32 AM in the corridor adjacent to the administration area looking towards the facility revealed that no exit sign could be observed in the corridor. Additionally, observation of the doors at either side of the separate COVID isolation area located | K 293 | K293<br><br>Corrective Actions: Exit signs are being installed in the three areas, two on the 400 hall and one in the area adjacent to the administration area, on Wednesday December 1, 2021.<br>Identification of Others: Potentially all residents and staff can be affected by the absence of lighted exit signs in an emergency.<br>Systemic Changes: The Maintenance staff were educated on the need to have and maintain appropriate exit signage. | 12/2/21 |

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| K 293 | Continued From page 5<br>in hall 400 revealed that no exit sign could be observed directing occupants to an exit.<br><br>Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.1.1, 7.10.1.5.1<br>. | K 293 | The presence of illuminated exit lighting and exit signs was added to the TELS Preventative Maintenance (PM) system to be inspected monthly on an ongoing basis. Any problem with exit signage during the monthly PM check will require immediate repair.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br><br>Compliance date: 12/2/2021 | |
| K 293<br>SS=D | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) | K 293 | | 11/29/21 |

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| K 293 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain exit signs in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain exit signs as required could result in injury or death. The deficiency affected one (1) of numerous doors in the facility. The findings were:<br><br>Observation on 11/2/2021 at 1:07 PM in the dining room revealed a set of doors at either side of the room that lead to the exterior courtyard. Further observation revealed that the doors could be confused as an exit, and that one set of doors was not provided with a sign reading "NO EXIT".<br><br>Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 19.2.10.1; 7.10.8.3.1 | K 293 | K293<br><br>Corrective Actions: A sign was placed on the door stating “No Exit”.<br>Identification of Others: Potentially residents and staff in the Alzheimers Unit could be affected by confusing the unmarked door leading to the enclosed courtyard as an exit door.<br>Systemic Changes: The Maintenance staff were educated on the need for clear signage to indicate exits and non-exits in the event of an emergency. The inspection of exit doors and non-exit doors was added to the TELS Preventive Maintenance (PM) system to be inspected monthly on an ongoing basis. Any problem with correct signage on the doors will be addressed immediately.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. | |

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| K 293 | Continued From page 7 | K 293 | Compliance date: 11/29/2021 | |
| K 325 SS=D | Alcohol Based Hand Rub Dispenser (ABHR)<br>CFR(s): NFPA 101<br><br>Alcohol Based Hand Rub Dispenser (ABHR)<br>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:<br>* Corridor is at least 6 feet wide<br>* Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols<br>* Dispensers shall have a minimum of 4-foot horizontal spacing<br>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room<br>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30<br>* Dispensers are not installed within 1 inch of an ignition source<br>* Dispensers over carpeted floors are in sprinklered smoke compartments<br>* ABHR does not exceed 95 percent alcohol<br>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)<br>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to store Alcohol-Based Hand-Rub (ABHR) in accordance with the 2012 NFPA 101, Life Safety Code. Failure to store ABHR as required could delay egress resulting in injury or death during an emergency. The deficiency affected one (1) of several storage rooms in the | K 325 | K325<br>Corrective Actions: The excess hand sanitizer that was stored in the PPE supply room was removed and disposed of by the Fire Department.<br>Identification of Others: Potentially all residents and staff can be affected by the | 11/29/21 |

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| K 325 | Continued From page 8<br>facility. The findings were:<br><br>Observation on 11/2/2021 at 11:20 AM in room 414 revealed that the room was being used as PPE supply storage. Additionally, it was observed that the room was storing 61.75 gallons of ABHR. Further observation could not establish that the room was fire-rated, that a closing device was provided at the door, or that the ABHR was stored in a protective cabinet.<br><br>Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated unawareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101: Section 19.3.2.6(7); 2012 NFPA 30<br>. | K 325 | improper storage of a flammable substance.<br>Systemic Changes: The Maintenance staff were educated on the need to store chemicals properly, have a door closure on the door if storage is occurring, and to limit the amount of alcohol-based hand sanitizer stored in the PPE Supply room. The inspection of storage rooms in the facility was added to the TELS Preventative Maintenance (PM) system to be inspected monthly on an ongoing basis. Any problem with the storage areas or failure to meet NFPA 101 will result in immediate remedy.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br><br>Compliance date: 11/29/2021 | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing | K 353 | | 11/29/21 |

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| K 353 | Continued From page 9<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain ceiling tiles in accordance with the 2012 NFPA 101, Life Safety Code. The failure to maintain ceiling tiles as required could result in delayed activation of the sprinkler system due to heat loss, resulting in injury or death. The deficiency affected one (1) of numerous resident rooms in the facility. The findings were:<br><br>Observation on 11/2/2021 at 11:35 AM in resident room 408 revealed that a 24" x 24" ceiling tile had an approximatly 22" diameter hole centered about the middle of the tile. In an emergency, smoke and heat would be able to bypass the smoke detector and the sprinkler head delaying activication of protective systems.<br><br>Interview with the facility maintenance manager at | K 353 | K353<br><br>Corrective Actions: The ceiling tile was replaced.<br>Identification of Others: Potentially all residents and staff could be affected by a delay in activation of the sprinkler system due to heat loss through a hole in a ceiling tile.<br>Systemic Changes: The Maintenance staff were educated on the need to have ceiling tiles intact. Inspection of ceiling tiles was added to the TELS Preventive Maintenance (PM) system to be inspected monthly on an ongoing basis. Any problems with ceiling tiles will require immediate repair or replacement.<br>Monitoring: The facility Administrator is responsible to make sure the TELS | |

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| K 353 | Continued From page 10<br>the time of observation acknowledged the deficiency, and indicated unawareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections: 4.6.12.2<br>. | K 353 | system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br>Compliance date: 11/29/2021 | |
| K 355 SS=F | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to conduct fire extinguisher inspections in accordance with the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to conduct fire extinguisher inspections as required may lead to extinguishers not functioning properly, which could result in injury or death during an emergency. The deficiencies affected several of numerous fire extinguishers in the facility. The findings were: | K 355 | K355<br>Corrective Actions: An audit was conducted of all fire extinguishers. An inspection was completed and documented for all that were not signed off in October 2021.<br>Identification of Others: Potentially all residents and staff could be affected by a faulty extinguisher in an emergency.<br>Systemic Changes: The Maintenance staff were educated on the need to have | 11/29/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535057 | A. BUILDING **01, 02**<br>B. WING _____ | **11/02/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOSHEN HEALTHCARE COMMUNITY** | **2009 LARAMIE STREET**<br>**TORRINGTON, WY 82240** |

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|---|---|---|---|---|
| K 355 | Continued From page 11<br>Observation on 11/2/2021 at 10:45 AM in the corridor by the activities room found the fire extinguisher not signed off or inspected for October of 2021. Further observation found an additional fire extinguisher by four hundred (400) hall nurses station where the signoff for October of 2021 was also missing. Additional observation found several other extinguishers throughout the facility also missing the October signoff.<br><br>Interview with the maintenance manager at the time of observation acknowledged the deficiency, and indicated awareness of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2010 NFPA 10: Section 7.2.1; 7.2.4 | K 355 | properly functioning and inspected fire extinguishers throughout the facility. Inspection of the fire extinguishers has been and continues to be a part of the TELS Preventive Maintenance (PM) system. A complete directory of all existing fire extinguishers was created to ensure full compliance with this system. The Maintenance staff will acknowledge the inspection occurred at every location monthly on an ongoing basis.<br>Monitoring: The facility Administrator is responsible to make sure the TELS system and schedule for PM is followed. The Administrator or designee will complete a monthly audit of compliance with the PM Schedule. These audits will be completed for no less than 3 months to ensure compliance. Any concerns identified during these audits will result in immediate educations 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 QAPI committee may modify this plan as needed to ensure that the facility remains in compliance.<br>Compliance date: 11/29/2021 | |