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 01/26/2023

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 1/23/23 to 1/26/23. Also reviewed in the course of the survey was complaint intake WY000003470. The following abbreviations were used throughout the document: ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nurse Aide LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or	F 680		2/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2023

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 680	Continued From page 1 occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the activities program was directed by a qualified professional. The census was 69. The findings were: 1. Random observations from 1/23/23 to 1/25/23 of the secure unit, Unit 200 and Unit 300 showed residents participating in various activities. 2. Interview on 1/25/23 at 11:55 AM with the activities director revealed she was a CNA and had not received special training to coordinate the activities program. 3. Interview on 1/26/23 at 9:50 AM with the human resources administrator confirmed the activities director did not receive training to coordinate the activities program.	F 680	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. F680 1. Corrective action: The Activities Director has enrolled in a CMS approved course offered by the National Certification Council for Activities Professionals (naccp.org) and is scheduled to complete coursework by May 12, 2023 and receive the Activity Professional Certified (APC) certification. The facility will consult with the Occupational Therapist for approval of the monthly activities calendar until the Activities Director receives the APC certificate. 2. Identification of other residents: All residents have the potential to be affected by the qualifications of the Activities Director. 3. Systemic changes: The passing of the exam will be audited for completion. Information regarding certification	

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F 680	Continued From page 2	F 680	requirements will be incorporated into the job description for the Activities Director position. In the event an Activities Director is not APC certified the facility will use an appropriate consultant to approve planned activities. 4. Monitoring: The Administrator is responsible for monitoring the exam completion and monthly audits to ensure the activities calendar is approved by the therapy consultant. Documentation of exam completion will require a one time audit. Exam completion and monthly audits will reviewed in QA. Compliance Date: 2/28/23	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview. medical record review, and policy review, the facility failed to ensure residents received adequate supervision and assessment for 1 of 1 sample residents (#72) reviewed for accident hazards. The findings were: 1. Review of the admission MDS assessment dated 8/8/22 showed resident #72 had diagnoses which included acute embolism and thrombosis,	F 689	F689 1. Corrective action: Resident #72 no longer resides at the facility. 2. Identification: All residents who currently reside at Goshen Healthcare have the potential for falls and are at risk. 3. Systemic changes: The Fall Prevention policy and procedure was reviewed and the neurological assessment was revised. On or before	2/28/23

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F 689	Continued From page 3 cancer, deep vein thrombosis, arthritis, and non-Alzheimer's dementia. Further review showed the resident received an anticoagulant 6 of the 7 days during the look back period. Review of the care plan showed the resident had a risk of falls and required staff assistance of one for transfers to bed, mobility, and toileting. Review of the "at risk for further fall" careplan last revised on 8/14/22 showed the resident had difficulty maintaining sitting balance, impaired balance during transitions, and had several risk factors for falls which included arthritis, delirium, wandering, cognitive impairment, dementia, depression, incontinence, hearing impairment, and pain. Interventions included staff of 1 to assist to ambulate with a walker to all destinations and therapy services to assist in reaching highest practicable level. Review of the fall risk assessment dated 8/1/22 showed the resident was at risk for falls and fall prevention protocols included "a new admission, ambulated on own, did not wait for assistance, and wandered often." The following concerns were identified: a. Review of a progress note dated 8/4/22 and timed 10:16 PM showed "...resident unwitnessed fall...resident fell out of [his/her] recliner chair sideways to the left side onto the floor..." Further review showed the resident complained of pain, had a contusion to the left wrist with edema noted in the left hand, had a skin tear to the right hand, and swelling to the forehead and the back of the head. The resident was sent to the emergency department at that time. Review of a fall risk assessment dated 8/4/22 showed the assessment was initiated; however, it was not completed. Review of the "Neurological Assessment Form" initiated on 8/4/22 showed the facility performed neurological assessments; however, the assessments	F 689	the date of compliance the DON or designee will reeducate licensed nursing staff and CNA□s on the updated "Fall Prevention" policy and procedure, including the requirement to complete fall assessments and neurological assessments per policy. Compliance Date: 2/28/23 4. Monitoring: The DON or designee will conduct audits of all fall occurrences to identify any deviations from fall and neurological assessment procedures 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 DON or designee until compliance is achieved. The QAPI committee may modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 2/28/23	

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F 689	Continued From page 4 stopped on 8/6/23. b. Review of a progress note dated 8/7/22 and timed 7:03 PM showed the resident was found on the floor next to his/her recliner. Further review showed the resident had a "...new hematoma to left knee cap and left forearm..." There was no evidence a fall risk assessment or neurological assessment was performed after the fall. c. Interview with the resident's representative on 1/25/22 at 4:55 PM revealed the facility did not have fall interventions in place, and the resident had two falls. Further interview revealed the resident was in a hall by his/her self, and there were no staff present on the hall to help the resident. d. Interview with RN #1 and RN #2 on 1/26/23 at 9:31 AM revealed staff from another hall were expected to check on and provide care to residents who lived on the hall resident #72 resided. Further interview revealed the facility's expectation was for staff were to check the residents at frequent intervals. e. Interview with the administrator on 1/25/23 at 3 PM revealed nurse's were expected to perform a fall risk assessment after all falls. 2. Review of the "Fall Prevention" policy and procedure last revised November 2022, showed "...Procedure: 1. A Fall Risk Assessment will be completed at the following times: a. Upon admission/readmission to the facility...d. Change of condition. e. Post fall... 3. Incident report and A fall scene investigation form will be completed after each fall. 4. Falls will automatically be logged through completion of Incident Report in PCC. 5. Initiate Neuro checks if resident hit head or if unwitnessed fall."	F 689		

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F 755	Continued From page 5	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and professional standard review the facility failed to administer medications as	F 755	F755 1. Corrective action: Resident #32□s	2/28/23

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F 755	Continued From page 6 physician ordered for 1 of 1 sample residents reviewed (#32) for pain management. The findings were: 1. Review of the quarterly MDS assessment dated 12/14/22 showed resident #32 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment, and diagnoses which included hemiplegia, cerebral infarction, cerebrovascular accident, repeated falls, personal history of (healed) other pathological fracture, and vascular dementia. Further, review showed the resident had a scheduled pain medication. Review of the physician orders dated January 2023 showed the resident was to receive tramadol (opioid pain medication) 50 milligram (mg) tablet every six hours. Review of the care plan initiated on 4/9/20 showed for pain: "I have pain/discomfort related to low back pain and bilateral knee pain. Please provide me with pain medications as ordered,". The following concerns were identified: a. Review of the resident MAR for tramadol 50 mg tablet showed the facility failed to administer the medication on 1/21/23 at 12 AM and 6 AM, on 1/22/23 at 6 AM, 12 PM and 6 PM and on 1/23/23 at 12 AM, 6 AM, and 12 PM. Further review showed the 6 PM medication was unavailable on 1/23/23. Review of the pain monitoring for January 2023 showed the resident had pain ranging from 7 to 9 during those days. b. Interview with the resident on 1/25/23 at 9:43 AM revealed, "I'm always in pain. I knew I was not getting the tramadol, and I needed it to control the pain." c. Interview with LPN #1 on 1/25/23 at 9:24 AM revealed if the medication cart was out of a narcotic they get a narcotic request code for the automated medication dispensing cabinet and	F 755	oral pain medication order was fulfilled by the pharmacy and medication was available and provided beginning with the noon dose on 1/24/23 unless the resident was sleeping. 2. Identification: All residents prescribed oral medications who reside at Goshen Healthcare have the potential to be affected by medications not being available. 3. Systemic changes: The oral medication ordering system was reviewed and revised to ensure medications are ordered and delivered in a timely fashion, and to ensure the automated medication dispensing system can be accessed by staff during all time frames. Staff will be educated on the revised procedure for ordering oral medications and how to access automated medication dispensing system. Staff will fill out form indicating date order placed, with resident and medication information. Unit Manager or designee will review order form for dates medications are ordered and dates received, and contact pharmacy if medication not received within expected timeframe. Compliance Date: 02/28/2023 4. Monitoring: The DON or designee will conduct audits Monday through Friday of all oral medications daily ordered to identify any deviations from expected delivery times 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 DON or designee until compliance is achieved. The QAPI committee may	

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F 755	Continued From page 7 administer the medication that way. She further stated she was not sure why the medication was not given. d. Interview with Unit Manager on 1/25/23 at 9:45 AM confirmed the resident had not received the tramadol. She was unaware of why the medication was not given. Interview with the unit manager on 1/25/23 at 9:54 AM revealed she had contacted the pharmacy and found out the delay was due to a new written prescription the pharmacy system failed to identify. e. Review of web page "National Library of Medicine," "Nursing Rights of Medication Administration," retrieved 1/31/23, showed "...Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration... 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms."	F 755	modify this plan as needed to ensure that the facility remains in compliance. Compliance Date: 02/28/23	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		2/28/23

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F 880	Continued From page 8 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; (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	F 880		

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F 880	Continued From page 9 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 review the facility failed to ensure infection control procedures were followed during an observation of wound care for 1 of 1 sample resident (#65) observed. The finding were: 1. Observation on 1/25/23 at 9:36 AM showed LPN #2 performed wound care to resident #65. The nurse used scissors to remove the contaminated dressing to right lower extremity, and placed the scissors on the floor. The nurse picked up the scissors from the floor, without disinfecting them, cut a piece of clean gauze. The	F 880	F880 1. Corrective action: The nurse (LPN #2) providing wound care identified in the deficiency was re-educated on policy “Dressings Clean/Aseptic” for nonsterile dressing changes on 1/27/23. The Director of Infection Prevention completed a DPOC phone interview with Mountain Pacific Quality Health to review systems on 2/16/23. All RN and LPNs are able to perform nonsterile dressing changes as part of their scope of practice and will be re-educated on policy and procedure for	

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F 880	Continued From page 10 nurse opened another package of gauze and the gauze fell onto the floor. The nurse picked up the gauze off the floor, and used the scissors to cut the gauze. She placed the cut piece of gauze onto the resident's wound. When the wound care was completed, the nurse placed the scissors and the open package of gauze that had fallen onto the floor into the resident's dressing supply box. Interview with the nurse at that time confirmed she did not disinfect the scissors after it touched the patient's wound and the floor. She further stated she should have thrown the gauze dressing that had fallen onto the floor away. 2. Interview with RN #2 on 1/25/23 at 12:24 PM revealed the expectation was for staff to disinfect contaminated equipment and to throw out any clean dressing supplies that were contaminated. 3. Review of policy "Dressing Clean/Aseptic" last revised July 2018 showed " ...26. If scissors used, wipe with disinfectant wipe ....."	F 880	aseptic technique during nonsterile dressing changes by 02/28/23. 2. Identification of others: All residents at the facility have the potential risk for wounds which would require wound care that meets standards of practice for infection control. 3. Systemic changes: Wound care boxes will include will disinfecting products to ensure items are able to be cleansed during wound care, to align with the facility policy for "Dressing Clean/Aseptic." The policy will be provided and discussed with RNs/LPNs upon hire by the Director of Infection prevention or designee and be included in yearly education thereafter. 4. 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 and when significant compliance is achieved, then monthly times three months. Any concerns identified during these audits will result in immediate education and corrective action. Results of the audits and staff training will be reported at the QA&A meeting by the Infection Preventionist or designee, the QAPI committee may modify this plan as needed to ensure that the facility reaches and remains in compliance. Compliance Date: 02/28/23	