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 12/13/2023

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 complaint survey was conducted by Healthcare Licensing and Surveys from 12/12/23 to 12/13/23. The survey was prompted by complaint intakes WY00003750 and WY00003690.	F 000		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;	F 887		1/18/24

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

Electronically Signed | 01/08/2024

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 12/13/2023

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 887	Continued From page 1 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident representative interviews, and review of incident reports and facility policies, the facility failed to ensure a resident's choice to refuse COVID-19 vaccination was honored for 1 of 6 sample residents (#6). The findings were: 1. Review of the 10/18/23 quarterly Minimum Data Set (MDS) assessment for resident #6 showed the resident had diagnoses which included dementia, COPD, and diabetes and had severely impaired cognition. Review of the resident's immunization record showed the	F 887	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 surveyor's findings or conclusions are accurate, that the findings constitute at deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	

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 12/13/2023

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 887	Continued From page 2 resident was vaccinated for COVID-19 on 9/21/21 and 12/5/23. The two entries prior to 12/5/23 showed consents were refused. Review of the care plan last revised 12/29/22 and initiated 11/25/22 showed "my family chooses for me to not have further Covid-19 booster vaccinations" and "staff will assist in decision making as instructed by my family or resident." Review of the "RESIDENT COVID-19 CONSENT OR DECLINATION" signed on 8/2/22 by the resident representative showed the vaccine was refused due to a serious reaction in the past. The following concerns were identified: a. Review of a physician's order written on 12/5/23 showed a COVID-19 vaccine was to be administered. b. Review of the 12/6/23 at 4:08 PM nurse progress note showed "Resident appears not to be feeling well, she is tense, when [s/he] is touched, fellin [sic] well. Not eating well very tired." Review of a 12/7/23 nurse progress note timed at 2:15 PM showed the medication error was discussed with the power of attorney (POA) regarding COVID-19 vaccination. "[S/he] is more lethargic than baseline, eyes are open and does respond to DON [director of nursing]." A progress note dated 12/7/23 at 4:36 PM showed the resident was not feeling well, and the spouse visited and was informed the resident was given the COVID-19 vaccine. The spouse stated s/he did not want the resident to receive the vaccine and was upset. c. Review of a medication error incident report showed on 12/5/23 the resident received the COVID-19 vaccine in error as the POA did not wish for the resident to receive the vaccine. The resident had been more lethargic since the vaccine injection. Review of the December treatment administration record (TAR) showed	F 887	Completion date: 01/18/2024 F 887: 1. Corrective action: Resident #6 COVID-19 vaccination information was updated on 12/5/23, the day of the medication error was discovered. His/ her instructions and Care Plan reflect he/she is to receive no further COVID-19 vaccinations and POA signed consent/declination form which was scanned into the resident's Electronic Medical Record. 2. Identification: All residents who currently reside at Goshen Healthcare have the potential to be affected. All current resident's Electronic Medical Record have been audited to ensure vaccination declinations are in place and are reflected on the resident's Care Plan. 3. Systemic Changes: Policy and procedure were reviewed and modified to reflect all vaccination consent/declination forms will have a written signature from the resident or the resident's representative. Verbal consent/declination will be accepted but will require written confirmation prior to vaccination being administered. The vaccination forms will be discussed and reviewed with the resident and/or resident representative on all new admissions at the 72-hour Care Conference Meeting. Education will be completed with Licensed Nurses. 4. Monitoring: Director of Nursing and/or designee will review all vaccination forms	

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 12/13/2023

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 887	Continued From page 3 the resident had no pain from 12/1/23 to 12/12/23, except on 12/6, 12/7, and 12/8 after receiving the COVID-19 vaccine. d. Interview with the resident representative on 12/13/23 at 10 AM revealed the staff told him/her they did not totally check the resident paperwork because the resident had a bad reaction to the COVID-19 vaccine in the past. S/he stated the facility never asked him/her to sign anything until after s/he was notified the resident was erroneously given the COVID vaccine. e. Interview with the infection control registered nurse (RN) on 12/13/23 at 10:30 AM revealed the resident was given the COVID-19 vaccine as a result of human error and s/he did become lethargic after the vaccine was given. Interview with the chief operating officer (COO) on 12/13/23 at 2:44 PM revealed it was the facility expectation for nurses to follow the resident or resident representative wishes and to follow the physician ' s orders. 2. Review of the facility's policy "Infection Prevention and Control Practices During COVID-19 Pandemic" revised May 11, 2023 showed " ...Upon admission COVID-19 immunization status for residents is recorded. Residents (and their representatives) that are not up-to-date are encouraged to receive the vaccination. They receive information and counselling [sic] regarding the risks and benefits of the vaccine and have an opportunity to ask questions and discuss concerns. A form reviewing the risks and benefits of COVID-19 vaccination including acceptance or declination of the vaccination is completed ..."	F 887	following the 72 Hour Care Conference meeting to ensure completion of consent/declination form. DON and/or designee will monitor compliance weekly for 1 month and then monthly for 4 months all new admissions. Results of audits will be reported and reviewed by the facility QAPI Committee. The QAPI Committee may make further recommendations and modify this plan as needed to ensure compliance.	