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 01/23/2024

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 on 1/23/24. The survey was prompted by complaint intake(s) WY000003769 and WY000003783. The following common abbreviations are used throughout this document: ADL: Activities of Daily Living CNA: Certified Nursing Assistant IP: Infection Preventionist RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		1/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/13/2024

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 585	Continued From page 1 to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to	F 585		

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F 585	Continued From page 2 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on grievance log review, staff interview, and policy and procedure review, the facility failed to ensure resident grievances were resolved for 2 of 3 sample residents (#2, #3). The findings were:	F 585	F585 1. The grievance for resident #2 was	

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F 585	Continued From page 3 1. Review of a "Grievance/Concern Report Form" dated 12/4/23 at 9:15 AM showed resident #3's representative notified the facility of concerns related to positioning, hydration, and activities of daily living. Further review showed no action or resolution by the facility. 2. Review of a "Grievance/Concern Report Form" dated 12/26/23 and untimed showed resident #2's representative notified the facility of concerns related to cleanliness and maintenance needs. Further review showed no action or resolution by the facility. 3. Interview with the health information management RN on 1/23/24 at 2:13 PM confirmed the grievances were not addressed, and she would have them addressed right away. 4. Review of the policy and procedure "Grievance/Concerns hand delivered on 1/23/24 at 4:40 PM by the Business Office Manger showed "...4. ...b. ...facility's policy is to complete and review results with resident/resident representative within 72 hours of receipt of concern/grievances..."	F 585	resolved on 1/26/24. Resident #3 no longer resides at the facility but in a care discussion between family members and the Director of Nursing, the family offered no complaints about care, hydration, positioning, etc. 2. The grievance log was reviewed for the last 12 months, and no other grievances were unresolved. 3. The facility has and continues to have a comprehensive grievance procedure and process. The Social Services Director receives all grievances and presents them to the leadership team in the morning standup meeting. The Social Services Director also logs them and files them when complete. The Administrator assigns them to the appropriate person for follow-up and tracks them through completion. Grievances are discussed each weekday until they are resolved. The facility makes every effort to resolve grievances within 72 hours of receiving them. Staff have been re-educated on the Grievance Procedure and process. 4. The Administrator is responsible for monitoring the grievance process. This is done each business day in the morning stand-up meeting. Monitoring of grievances will be ongoing as stated above. Grievance logs will be brought to the QA committee for a period of 3 months for review to ensure the process is being followed. 5. Completion date: 1/26/24.	

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and resident rights review, the facility failed to ensure residents received care in accordance with the care plan for 1 of 5 sample residents (#1). The findings were: 1. Review of care plan for resident #1 last revised on 1/7/24 showed "ADLs: [residents' name] needs mostly extensive assistance with ADLs. [S/he] has diagnoses of Parkinson's and Tremors. [S/he] has required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, hygiene and bathing. [S/he] needs total assist with meals/eating. [S/he] has a BIMS [brief interview for mental status] score of 14 (cognitive intact). The following concerns were identified: a. Observation on 1/23/24 at 12:15 PM showed the resident sitting in a wheelchair with an over the bed table in front of him/her and an untouched open lunch meal plate in front of the resident. Interview with resident at that time revealed s/he needed help eating the meal. The plate was a ribbed plate and the utensils had large grips. Further, observation showed CNA #2 was in the room placing a sheet on the resident's	F 684	F684 1. The care plan for resident #1 was reviewed for eating assistance required. Staff were re-educated on the care plan and the resident is now receiving physical assistance to eat. The C.N.A. observed during the survey fixing the bed in the room was re-educated on the meal process for residents with meal trays who require physical assistance to eat. 2. Care plans for residents in the facility were reviewed for eating assistance required and found to be accurate. Eating assistance is on each Kardex to instruct the C.N.A.s and Nursing staff on the care required for residents. 3. Nursing and dietary staff were re-educated on the process for meal assistance and tray pass to include that the tray is only passed when the resident has staff available to assist the resident.	2/22/24

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F 684	Continued From page 5 bed. The CNA stated at that time "someone will come in and feed [him/her.]" b. Interview with CNA #2 on 1/23/24 at 12:25 PM revealed the resident "refused to eat." Continued observation showed the director of dietary services entered the room and checked the food temperatures. At that time, the temperature of the green beans was 127 degrees Fahrenheit, and the temperature of the macaroni and cheese was 91.9 degrees Fahrenheit. The director of dietary services revealed meal trays were delivered to rooms at noon. c. Interview with the IP on 1/23/24 at 4:15 PM revealed the facility would expect the CNA to assist the resident with the meal instead of making the bed. 2. Review of the "Resident Bill of Rights" showed "...You have the right to be treated with dignity and respect... You have the right to decide when you go to bed, rise in the morning, and eat your meals..."	F 684	It is only at that time that the food is to be uncovered to ensure the temperature of the food is maintained. No other care is to be provided during mealtimes unless in an emergency. 4. The Director of Nursing is responsible for ensuring that care is delivered per the care plan. The tray pass process will be observed at least weekly on an ongoing basis to ensure residents who require assistance with their meals receive assistance and that the food is served at palatable and safe temperatures. These audits will be reviewed by the QA committee for a period of 3 months. 5. Completion date: 2/22/24.	