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 02/04/2025

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys on 2/3/25 through 2/4/25 which was prompted by complaint intakes WY00003968, WY00004106, WY00004174, and WY00004188. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant LPN: Licensed Practical Nurse NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 605		3/12/25

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

Electronically Signed | 02/27/2025

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F 605	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility's investigation report, review of the state agency incident report, staff interview, and policy and procedure review, the facility failed to ensure residents were free from chemical restraints intentionally imposed for staff convenience for 2 of 8 sample residents (#7, #8). The findings were: 1. Review of the facility's investigation report showed the facility administration received information from CNA #1 on 12/10/24 at approximately 3:45 PM. CNA #1 was concerned LPN #1 "was medicating residents on the Alzheimer's unit with meds that are not ordered for them. [LPN #1] was overheard making a statement...I give them a little bit of extra of mine, but not enough so that when I go to the doctor, they won't refill me." CNA #1 stated she heard the statement from LPN #1 approximately 1 week ago and was unsure if it "was a joke or serious." Further review of the statement from CNA #1 showed "she was concerned last Wednesday and Thursday because three residents who received medications appeared sedated shortly after receiving them...LPN #1 offered to put three residents to bed at an early hour just after	F 605	F605 1. Nurse #1 was immediately suspended pending investigation when Administrator received initial allegation from a staff member. Nurse #1 confessed to giving two residents medications in the evening that were not prescribed for them. All were over-the-counter medications. Nurse #1 resigned the day after the allegation was received. Medical Director, resident responsible parties, Pharmacy Consultant, and all appropriate agencies including the Wyoming Board of Nursing, Wyoming Department of Health, and local police were notified timely of the incident. Known residents given medications not prescribed by their physicians by Nurse #1 were reviewed for adverse effects by the Pharmacy Consultant and Psych/Pharm committee. 2. A review of medication administration records was conducted for residents residing in the unit Nurse#1 worked. Staff were questioned about unusual symptoms such as fatigue for any residents in the	

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F 605	Continued From page 2 supper." 2. Review of the facility's investigation report showed the NHA approached LPN #2, who was on duty in the secure unit on 12/10/24 at approximately 5 PM, who produced a bottle of Tylenol 325 mg tablets (100) with a date written on it in red ink of 12/6/24. LPN #2 confirmed she had opened the bottle and had dated it. Upon opening the bottle on 12/10/24 LPN #2 noted three pink tablets in the bottle with approximately 30 tablets of Tylenol. The NHA "took the bottle...as evidence." The count of Tylenol pills inside the newly opened bottle was 29 tablets and 3 Benadryl tablets." 3. On 12/11/24 LPN #1 was questioned by the facility and confessed to administering two residents medications that were not ordered. These residents were resident #7 and resident #8. LPN #1 admitted to administering Tylenol, melatonin (a hormone which plays a role in sleep), and Benadryl (an antihistamine which may have a sedative effect); however, LPN #1 could not remember who all of the residents were that she had given the medications to. In addition, the LPN stated she had been medicating the residents since 11/1/24 when she became a full-time employee. 4. Review of a complaint form submitted to the Wyoming Board of Nursing on 12/11/24 at 12:41 PM showed "Information had come to the employer that [LPN #1] may be giving residents medications that are not prescribed to them. The original complaint did not know what kind of medications or if they were prescription medications belonging to [LPN #1]. The report is that residents were complaining of "feeling funny"	F 605	unit as part of the investigation. 3. Nursing staff will be educated on Chemical Restraints to include the definition, regulatory compliance, signs and symptoms, and how to report suspicion of chemical restraint. 4. The Director of Nursing is responsible for ensuring Residents are not chemically restrained. The facility has and will continue to hold monthly Psych Pharm committee meetings in which each resident receiving a psychotropic medication is reviewed as needed and a minimum of quarterly to avoid any unnecessary medications. The facility has and will continue to obtain consent from residents or responsible parties prior to giving a psychotropic medication, or changing the dosage. The Director of Nursing or designee will conduct weekly audits of at least 20% or 5 licensed nurses and Medication Aides for competence on the definition of Chemical Restraint, signs and symptoms of Chemical Restraint, and how to report known suspicions of chemical restraints for a minimum of 3 months. Results of these audits will be brought to the QA committee for review. The QA committee will determine after 3 months if the audits should continue. 5. Completion date: 3/12/25	

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after being given medications by this particular nurse. Also, CNA staff reported finding some residents unusually tired or "out like a light" for the entire night, which raised suspicions. All residents involved have dementia diagnoses and are admitted to a secured memory care unit for their safety. On December 10, 2024 [the NHA and executive director] began investigating the allegations. During the initial investigation, it was discovered that a generic acetaminophen 325 mg bottle in the medication cart contained three pink caplets with the inscription of "S4" on one side that was hidden among the tablets of acetaminophen. It was noted that the bottle had been labeled and put into service on December 6, 2024. The bottle contained 100 tablets at opening. There were 61 tablets of acetaminophen missing from the bottle. Only one resident on the unit receives this medication regularly and no more than 9-12 tablets should have been taken from this stock bottle. It should be noted that [facility name] has a strict "no Benadryl" policy for the patient population and that no resident is ordered this medication in any form. [LPN #2] advised that she had discovered the pink caplets on December 10, 2024, and the caplets were not present the day before. The only other staff member with access to the medication cart at that time was [LPN #1]. On December 11, 2024 [the NHA and executive director] conducted a telephone interview with [LPN #1] regarding the allegations and the unapproved medications located in the medication cart. Immediately upon beginning the interview, [LPN #1] stated "I think I am going to pivot away from nursing and just terminate my employment immediately." During that recorded interview, [LPN #1] admitted to giving two residents combinations of "Tylenol, Melatonin, and Benadryl" that were not ordered or

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prescribed to these residents. [LPN #1] mentioned that she had done this occasionally "when things got crazy over there" referring to the Alzheimer's Care Unit. [LPN #1] denied bringing in any outside prescription medications to provide to residents, however, it was noted that her response was delayed and lacked confidence..."

5. Interview with the NHA on 2/4/25 at 2:49 PM revealed the facility did not treat the incident as an allegation of chemical restraint because it was just "one nurse" who had administered unprescribed medications to the residents. The NHA stated she had notified the residents' representatives, physicians, and performed urine drug testing on the residents which could provide a urine sample; however, there was no documentation available. Further, the administrator stated the allegation was dealt with promptly and the appropriate agencies had been contacted; however, education had not been provided to staff on the use of chemical restraints.

6. Telephone interviews were attempted on 2/4/25 with LPN #2, CNA #1 (who was no longer employed at the facility) and LPN #1. These attempts were unsuccessful..

7. Review of the "ABUSE PREVENTION PLAN (WY)" policy, last revised October 2017, showed "...CHEMICAL RESTRAINT: Any drug that is used for discipline or convenience and not considered accepted professional practice to treat medical or behavioral symptoms. Examples include but are not inclusive: Attempting to alter the individual's behavior with inappropriate use of drugs...Staff administer a medication to sedate or subdue the resident..."

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's investigation report, medical record review, staff interview, and review of policy and procedure, the facility failed to complete and maintain documentation for 1 of 3 allegations of abuse investigations reviewed. The findings were: 1. Review of the facility's investigation report showed CNA #1 reported to facility administration on 12/10/24 at approximately 3:45 PM an allegation that she suspected LPN #1 was administering medications to residents in the secure unit which were not prescribed for them. The facility immediately suspended LPN #1 and began an investigation. The following concerns were identified: a. Review of the facility's investigation report	F 610	F610 1. a. and b. The facility immediately conducted an investigation for Physical Abuse of residents by Nurse #1. Drug screens typically used for employees were conducted on 5 of 8 residents that the investigators determined may have been medicated by this nurse as they typically have behaviors in the evening. These 5 tests were done on individuals who can urinate in a clean container for testing. Three of the eight were incontinent. These tests, all negative, were completed as a baseline step to determine who may have been medicated and with what medication, in a complicated allegation. This was not documented in individual	3/12/25

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F 610	Continued From page 6 showed 8 residents were identified which may have been affected; however, review of the residents' medical records failed to show documentation of the allegation or notification of the residents' representatives or primary care providers. b. Review of the facility's investigation report showed the facility performed urine drug testing on the residents in the secure unit; however, there was no evidence the results of the urine drug tests were retained. c. Review of the facility's investigation report showed the medical director and consultant pharmacist had been consulted. Interview with the consultant pharmacist on 2/4/25 at 1:43 PM confirmed she had been consulted; however, there was no documentation in the investigation report related to the consultation. Further interview with the pharmacist revealed there were too many variables present to determine what the side effects, described by the residents and staff, were the result of. The medical director was unavailable. d. Interview with the NHA on 2/4/25 at 12:09 PM revealed she had notified the residents' representatives and primary care providers for the two residents LPN #1 had confessed to administrating unprescribed medications; however, did not document the allegation in the residents' medical record. In addition, the NHA stated she had convened an adhoc QAPI (quality assurance performance improvement) meeting to discuss the allegation; however, the minutes of the meeting were not available. An additional interview on 2/4/25 at 12:45 PM revealed the facility did not treat the incident as an allegation of chemical restraint because it was just "one nurse" who had administered unprescribed medications to the residents and not a systemic problem.	F 610	records as it is part of an investigation which is a QA protected document, and all tests were negative. Had the tests been positive, the physician and responsible party would have been notified, further testing done per orders, and it would be documented in the record. For purposes of this citation, this was described more fully in the investigation file. c. The meeting held with the Medical Director and Consultant Pharmacist relating to this incident is now documented as an Ad Hoc QA Meeting and documented in the investigation file. d. Notes from the conversations with responsible parties for the known medicated individuals were added to the patient□s records. 1.2. The investigation file was revised and all elements are now present in the file. The incident was investigated under Physical Abuse. 2. Investigation files for reported events in the last 3 months were reviewed for completion and any missing elements were added. 3. The staff responsible for investigating events in the facility were re-educated on the elements of a complete investigation. Additional staff were added to the state portal for reporting and recording events and investigations. 4. The Administrator is responsible for the completion and of all investigations. A checklist is used to ensure all elements of the investigation are present. The Administrator will review all reportable investigations with the QA committee and any recommendations will be followed.	

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F 610	Continued From page 7 2. Review of the "ABUSE PREVENTION PLAN (WY)" policy, last revised October 2017, showed "...E. Investigation: 1...Facility will identify the staff member(s) responsible for: ... c. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; d. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause; e. Providing complete and thorough documentation of the investigation..."	F 610	This will be done for the next 3 months or longer as the QA committee determines the need. 5. Date of Completion: 3/12/25	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, review of the state agency facility reported incidents, staff interview, and review of the Wyoming Board of Nursing license verification portal, the facility failed to provide services which met professional standards of practice. The facility census was 69 of which 19 residents resided in the secure unit. The facility implemented corrective action prior to the survey and was determined to be in substantial compliance as of 12/19/24. The findings were: 1. Review of facility incident report filed with the state agency showed on 12/10/24 at 4 PM the facility received a concern from a CNA (identified	F 658	Past noncompliance: no plan of correction required.	

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F 658	Continued From page 8 as CNA #1) a night shift nurse (identified as LPN #1) may be administering medications which had not been prescribed to the residents. The following was the response from the facility: a. On 12/10/24 LPN #1 was suspended prior to clocking in for her shift pending an investigation. b. On 12/11/24 LPN #1 confessed to administering two residents with medications which had not been prescribed "to make them sleep on 'crazy nights'". LPN #1 resigned at that time. c. Review of a 12/11/24 letter showed the Board of Nursing was notified and a complaint was filed. d. Review of the Wyoming State Board of Nursing showed LPN #1's license was terminated on 12/19/24. 2. Interview with the NHA on 2/4/25 at 12:09 PM confirmed LPN #1 had resigned immediately after being interviewed, the Wyoming Board of Nursing was notified immediately, and LPN #1's license to practice was suspended.	F 658		