STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goshen Healthcare Community	**2009 Laramie St , Torrington, Wyoming, 82240**

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F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/21/25 through 7/24/25. The following common abbreviations are used throughout this document: CNA: Certified Nursing Assistant MDS: Minimum Data Set DON: Director of Nursing GDR: Gradual Dose Reduction MAR: Medication Administration Record MRR: Medication Regimen Review Less commonly used abbreviations will be annotated in each deficiency.	F0000		08/15/2025
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information	F0628	1. Nurse responsible for presenting/completing Bed Hold notice with the resident #10 was re-educated by the DON on the Bed Hold Policy and location of Bed Hold form on 8/12/25. 2. Licensed nurses will be re-educated on the Bed Hold Policy and location of Bed Hold forms at each nurses' station by the Nurse Educator/designee by 8/26/25. 3. Facility initiated a new process of having red folders that contain discharge instructions checklist and bed hold forms placed in see through wall mounted file folders at nurses' station as a visual reminder to complete forms. Nurse educator/designee will complete 2 times weekly audits of 3 licensed nurses each for comprehension of Bed Hold Policy and location of Bed Hold forms for 2 months then weekly audits of 3 nurses for 1 month. 4. The results of these audits will be reported by the Nursing Home Administrator/designee during the monthly QAPI meeting for 3 months for compliance, the need for further audits beyond 3 months or for changes to the	08/26/2025

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 reverse for further 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.

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

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F0628 SS = D	Continued from page 1 (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F0628	Continued from page 1 plan of corrections if needed.	

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F0628 SS = D	Continued from page 2 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F0628		

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F0628 SS = D	Continued from page 3 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary	F0628		

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F0628 SS = D	Continued from page 4 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff interview, and policy and procedure review, the facility failed to provide a bed hold policy for 1 of 3 sample residents (#10) reviewed for discharge. The findings were: 1. Review of the Notice of Transfer or Discharge dated 7/2/25 showed resident #10 was transferred to the Hospital ER on 7/2/25. The "Bed Hold Policy" box was marked; however there was no evidence a written bed-hold was provided to the resident or resident representative. 2. Interview with the DON on 7/24/25 at 9:40 AM revealed the resident or their representative should have received a packet which included a copy of the bed hold policy. Further interview revealed there should have been a note that showed the resident's representative was notified by telephone when s/he was discharged to the ER (emergency room). She reported the policy had been sent with the resident to the ER, and only the first page had been copied by the nurse and put in the resident's chart. The DON confirmed there was no evidence the resident or his/her family received the notice. 3. Review of the policy and procedure titled "Discharge Plan and Summary" and last revised March 2025 showed "...14. Written documentation will be given to resident or resident representative about payment needed to hold a bed when readmission/return is expected..."	F0628		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	1. CNA #1 was immediately re-educated on not to leave	08/26/2025

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F0689 SS = D	Continued from page 5 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, staff interview, and medial record review, the facility failed to ensure adequate supervision for 1 of 8 sample residents (#56) reviewed for accident hazards. The findings were: 1. Review of the quarterly MDS assessment dated 6/9/25 showed resident #56 had short-term and long-term memory impairment and diagnoses which included cerebrovascular accident and Alzheimer's dementia. Further review showed the resident had upper extremity impairment on one side, lower extremity impairment on both sides, and was dependent on staff for transfers. The following concerns were identified: a. Observation on 7/23/25 at 9:23 AM showed CNA #1 entered resident #56's room with a sit-to-stand style lift and placed a sling behind the resident. The CNA assisted the resident out of his/her wheelchair and into the bathroom. The CNA removed the resident's pants and brief, lowered the resident onto the toilet, locked the sit-to-stand lift's brakes, and left the bathroom. The resident remained in the bathroom, attached to the lift, without staff supervision. Observation on 7/23/25 at 9:29 AM showed the CNA returned to the resident's room and asked if s/he was done, then performed care and removed the resident from the bathroom, assisted him/her into the wheelchair, and removed the mechanical lift sling. b. Interview with the DON on 7/23/25 at 3:42 PM revealed a resident should not be left in the bathroom attached to a mechanical lift without staff present and the lift sling should be removed while residents were using the bathroom.	F0689	Continued from page 5 resident #56 unsupervised while on the toilet and still in the sling with sit-to-stand lift locked in front of resident # 56. 2. Nursing staff to be re-educated by the Nurse Educator/designee on not leaving residents unsupervised while still attached to sit-to-stand lifts. 3. Nurse Educator/designee to complete mechanical lift competencies with nursing staff by 8/26/25. Nurse Educator/designee to complete 3 times random weekly audits of 3 licensed nursing staff using sit-to-stand lifts to ensure compliance with supervision of residents while using lifts for 2 months, then 1 time weekly of 3 nursing staff for 1 month. 4. The results of these audits will be reported by the Nursing Home Administrator/designee during the monthly QAPI meeting for 3 months for compliance, the need for further audits beyond 3 months or for changes to the plan of corrections if needed.	
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On	F0756	1. Resident #55's Pharmacy Consultant recommendations were reviewed for past 3 months for completion by	08/26/2025

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F0756 SS = D	Continued from page 6 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to follow the pharmacist's recommendations for 1 of 5 sample residents (#55) reviewed for (MRR) medication review regimen. The findings were:	F0756	Continued from page 6 Director of Nursing on 8/12/25 with no other omissions noted. 2. Pharmacy Recommendations for the past 3 months will be reviewed by Director of Nursing /designee for current residents to ensure recommendations were acted upon and completed by 8/15/25 with corrections made if discrepancies are noted. 3. A new process of requiring a second nurse for noting/signing of pharmacy consultant recommendations was implemented on 8/10/25 to ensure Pharmacy Consultant Recommendations are acted upon and completed. Medical records staff member/designee to conduct weekly audits of Pharmacy Consultant Recommendations received that week for two nurse signatures for 3 months to ensure compliance with new process. 4. The Nursing Home Administrator/designee will report results of weekly audits during the monthly QAPI meeting for 3 months for compliance with reporting, the need for further audits beyond 3 months or for changes to the plan of corrections if needed.	

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F0756 SS = D	Continued from page 7 1. Review of a GDR dated 6/6/25 showed the pharmacist recommended a dose reduction of resident #55's trazadone (antidepressant) from 50 milligrams (mg) to 25 mg. Further review showed the recommendation was signed by the physician on 6/13/25, and the DON on 6/19/25. Review of a medication regimen review dated 7/7/25 showed the pharmacist wrote "Pharmacy recommendation for decrease in trazadone to 25mg qhs [every day at hours of sleep] was approved by Dr. there [sic] is still an order for 50mg qd [every day] in the chart." Further review showed it was signed and dated by the DON on 7/10/25. 2. Review of the resident's MAR showed the resident's trazadone dosage was not decreased until 7/10/25. 3. Interview with the DON on 7/24/25 at 9:40 AM revealed she did not know why the change was not implemented and confirmed it should have been performed on 6/19/25. 4. Review of the policy and procedure titled "Medication Regimen Review" provided by the facility showed "...7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR..." .	F0756		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F0880	1. Resident #8's physician's orders were reviewed for clarification of Droplet Precautions ordered which showed Droplet Precautions were discontinued on 7/19/24. Signage and PPE Bin were removed from outside resident's room on 7/24/25. Current residents' medical records were reviewed to identify residents requiring Enhanced Barrier Precautions. Signage and PPE Bins were placed on exterior of doorway as indicated on 8/25/25. Respiratory outbreak was reported to the State Health Officer and the Licensing Division on 8/8/25 to achieve compliance, the County Health Officer was notified of outbreak on 7/14/25. 2. Re-education will be provided by the Nurse Educator/designee to facility staff on Isolation Precautions and Enhanced Barrier Precautions with emphasis on appropriate PPE to be worn by 8/22/25. The facility COO educated the Nursing Home Administrator, Director of Nursing, Infection Control Preventionist, Nurse Educator and Facility Department Heads on the required reporting of diseases/conditions to the Wyoming Department of Health Epidemiology Department, County Health Officers and Licensing Division on 8/8/25.	08/26/2025

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F0880 SS = E	Continued from page 8 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 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.	F0880	Continued from page 8 3. Infection Control Preventionist to begin utilizing on 8/12/25 Nadona's "Daily Infection Audit Tool" for random audits at least weekly. Random weekly audits of 10 facility staff entering Isolations rooms and/or staff providing care for Enhanced Barrier Precaution residents for 3 months to ensure compliance with required PPE. Infection Control Preventionist/designee will track diseases/conditions daily during Morning Clinical Meeting for reportable diseases /conditions using the Wyoming Department of Health Reportable Diseases and Conditions List as well as tracking nosocomial diseases/conditions of 2 or more person for immediate reporting to the State Health Officer, the County Health Officer and the Licensing Division. The Director of Nursing/designee will audit tracking of diseases/conditions 2 times weekly for 3 months for compliance with reporting to appropriate/required agencies and documented on the Administrative Morning Meeting report. 4. The Nursing Home Administrator/designee will report results of weekly audits during the monthly QAPI meeting for 3 months for compliance with reporting, the need for further audits beyond 3 months or for changes to the plan of corrections if needed.	

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F0880 SS = E	Continued from page 9 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, resident and staff interview, and policy and procedure review, the facility failed to ensure personal protective equipment (PPE) was used for 2 of 9 sample residents (#8, #63) reviewed for infection prevention. In addition, the facility failed to report an outbreak of infectious disease involving 13 residents. The census was 74. The findings were: Regarding reporting facility outbreaks: 1. Observation on 7/21/25 at 2:40 PM showed the entrance doors had a sign that indicated the facility was experiencing an outbreak. Interview with the administrator at that time revealed the facility had several residents who were experiencing a respiratory illness. 2. Review of the state licensing agency incident database showed no evidence the facility had reported an infectious disease outbreak. 3. Interview with the infection preventionist on 7/24/2025 at 8:45 AM revealed 13 residents had experienced respiratory symptoms during the outbreak and he confirmed the outbreak was not reported to the licensing agency. Regarding appropriate PPE use: 1. Observation on 7/21/25 at 2:45 PM showed resident #8 had a sign on his/her door which indicated s/he was on droplet precautions and PPE was stored in a plastic container outside the room. a. Observation 7/21/25 at 5:45 PM showed an unidentified staff member entered the room for resident #8 to deliver a meal tray. No PPE was in use or donned prior to entering the resident's room. b. Interview with the infection preventionist on 7/24/25 at 8:45 AM precautions for the facility's outbreak had not been lifted. He confirmed staff should have worn PPE in resident #8's room until 7/23/25. 2. Review of the quarterly MDS assessment dated 6/24/25 showed resident #63 had a BIMS score of 13 out of 15, which indicated intact cognition and diagnoses which	F0880		

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F0880 SS = E	Continued from page 10 include urinary incontinence. Further review showed the resident had a stage II pressure ulcer. The following concerns were identified: a. Observation on 7/23/25 at 9:53 AM showed the DON and LPN #1 entered the resident's room to perform a dressing change. The DON and LPN #1 applied gloves and performed a dressing change to the residents wound. No other PPE was used. Further observation showed a sign on the back of the resident's door which indicated the resident was on enhanced barrier precautions. b. Interview with the DON on 7/23/25 at 10:15 AM confirmed that no gown was worn by herself or the LPN #1 while changing the resident's dressing. Further interview revealed "Enhanced barrier precaution procedures are a new practice to the facility and has not been fully implemented." c. Interview with the infection preventionist on 7/23/25 at 10:45 AM confirmed enhanced barrier precautions were not being performed to the national standard at this time. 3. Review of the policy titled "Transmission Based Precautions: Contact, Droplet and Airborne Precautions" dated 2014 showed "...Droplet Precautions... II. PPE A mask should be worn when entering the resident's room or cubicle. If substantial spraying or respiratory secretions ins [sic] anticipated, gowns ad [sic] gloves as well as goggles or face shield (in place of goggles) should be worn..."	F0880		
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview and policy and procedure review, the facility failed to ensure a system to monitor antibiotic usage. The census was 74. The	F0881	1. Re-education on Antibiotic Stewardship in Long-term care was provided by facility COO to the Infection Control Preventionist, Director of Nursing, Nursing Home Administrator and Nurse Managers on 8/13/25 using CDC' s Core Elements of Antibiotic Stewardship in Nursing Homes and Checklist for Core Elements of Antibiotic Stewardship in Nursing Homes. 2. A revised Antibiotic Stewardship Program will be developed and implemented by 8/22/25 utilizing CDC's Core Elements of Antibiotic Stewardship and QSEP-training resource. Revised program will include daily review of newly ordered antibiotics in morning clinical meeting to ensure antibiotic medications are reviewed when ordered for compliance with the revised program and not at the end of each month. 3. Director of Nursing/designee will review Antibiotic Stewardship documentation weekly for 3 months for compliance with revised Antibiotic Stewardship Program.	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0881 SS = E	Continued from page 11 findings were: 1. Interview with the infection preventionist on 7/24/25 at 8:45 AM revealed physicians ordered antibiotics while labs were pending and would change the antibiotic when the results were obtained. He revealed antibiotics were reviewed at the end of the month and not when they were ordered. He confirmed the facility had not implemented an antibiotic stewardship program. 2. Review of the facility policy titled "Antibiotic Stewardship Program (ASP)" dated 2016 showed "...5. Tracking a. IP [infection preventionist] will be responsible for infection surveillance and MDRO [multi-drug resistant organisms] tracking b. IP may collect and review data/measurements such as : i. Antibiotic prescription orders for completeness: dose, route, frequency, duration and indication...iv. Whether appropriate tests such as cultures were obtained before ordering antibiotic..."	F0881	Continued from page 11 4. The Nursing Home Administrator/designee will report results of weekly reviews during the monthly QAPI meeting for 3 months for compliance with reporting, the need for further audits beyond 3 months or for changes to the plan of corrections if needed.	