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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goshen Healthcare Community	2009 Laramie Street Torrington, WY 82240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 37220 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 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. (continued on next page)

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.

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37220 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 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. 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 .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 37220 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 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.