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	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goshen Healthcare Community	2009 Laramie St 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] showed resident #63 had a BIMS score of 13 out of 15, which indicated intact cognition and diagnoses which 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. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 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 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 .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 date d 7/2/25 showed resident #10 was transferred to the Hospital ER on [DATE]. 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 .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 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: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 .