STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, facility incident review, and policy review, the facility failed to ensure residents were free from sexual abuse for 2 of 3 residents (#2, #3) reviewed. The findings were: Review of the 7/29/20 quarterly MDS assessment showed resident #1 had [DIAGNOSES REDACTED]. The resident had a BIMS score of 5, indicating severe cognitive impairment. Review of the resident's care plan showed a plan dated 3/20/20 regarding sexually inappropriate behavior. The initial plan interventions included Close observation when in common areas near (male/female) residents-redirect if closer than arm's length away, and Identify physical or verbally inappropriate behavior (e.g. 'You are touching me' and 'You are standing too close'). The following concerns were identified: 1. Review of a facility reported incident that occurred on 3/19/20 showed CNA #3 witnessed resident #1 walking up to another resident (resident #2) who was sitting in the common area. Resident #1 approached the second resident from behind, bent over and slid his/her left hand into the second resident's pants while sliding his/her right hand under the second resident's shirt and grabbing the resident's left breast. At the time of the incident resident #2 was sleeping. The CNA reported this observation to RN #1, who documented the incident in nursing progress notes, but did not report the incident to facility administration. The facility's investigation further concluded sexual abuse had occurred. Review of the 5/10/20 significant change MDS assessment showed resident #2 had [DIAGNOSES REDACTED]. Both residents resided on the dementia unit. Further review of the facility incident report showed neither resident recalled the incident afterward. 2. Review of a facility reported an incident that occurred on 4/29/20 showed resident #1 was in the sunroom of the dementia unit and staff were in an adjacent common area. Resident #3 approached resident #1, and resident #1 asked him/her if s/he wanted to play. Resident #3 replied, No. Then resident #1 rubbed his/her hands on resident #3's breasts over his/her shirt, and began to reach inside the shirt. Resident #3 left and reported the behavior to facility staff. Resident #3 accurately described resident #1 as the perpetrator and stated s/he was fearful. The facility's investigation concluded sexual abuse had occurred. Review of the 5/19/20 quarterly MDS assessment showed resident #3 had a BIMS score of 11 (indicating moderate cognitive impairment). Review of the medical record showed no indication of a change in the resident's behavior. 3. Interview with the administrator on 8/11/20 at 5 PM revealed CNA #3 and RN #1 were no longer employed by the facility. The administrator confirmed the events of 3/19/20 and 4/29/20 occurred as described in the facility reports. 4. Review of the staff education sign-in dated 7/3/20 showed staff read and signed the following: Regarding (resident #1) in (resident's room number) (s/he) must be a 1 on 1 care at all times. This 1 on 1 caregiver cannot do any other duties. (The resident) has to have 1 staff with (him/her) at all times. 5. Review of the facility's undated policy titled Abuse Policy showed Each resident shall be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion .In instances of potential abuse, the facility shall employ procedures for immediate identification and investigation of the possible abuse, while protecting the resident(s); and shall report all finding in accordance with state and federal laws, requirements, and/or regulations.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on medical record review, staff interview, facility reported incident review, and policy review, the facility failed to report allegations of abuse to the State Survey Agency in a timely manner for 2 of 4 incidents reviewed (incidents involving residents #1, #2, an #3). The findings were: 1. Review of a facility report of an incident that occurred on 3/19/20 showed resident #1 approached resident #2 from behind and slid his/her hands under the resident's clothing and grabbed his/her breast. The incident was witnessed by CNA #3 and reported to RN #1, who documented an incident in progress notes, but failed to notify the facility administration of the incident. The incident was discovered the next day by routine quality review of nursing progress notes. Review of the State Survey Agency incident reporting logs showed the incident was initially reported to the agency on 3/20/20. 2. Review of a facility report of an incident that occurred on 4/29/20 showed resident #1 asked resident #3 if s/he wanted to play. Resident #3 responded, No and resident #1 proceeded to rub his/her hands over resident #3's breast over his/her shirt, and began to reach inside the resident's shirt. Resident #3 left and reported the incident to facility staff. Review of the State Survey Agency incident reporting logs showed the incident was initially reported to the agency on 5/6/20 (7 days later). 3. Interview with the administrator on 8/11/20 at 5 PM confirmed both incidents were reported to the State Survey Agency late and should have been reported within two hours after the allegation of abuse is made. 4. Review of the undated facility policy titled, Abuse Policy showed .Each resident shall be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion .In instances of potential abuse, the facility shall employ procedures for immediate identification and investigation of the possible abuse, while protecting the resident(s); and shall report all findings in accordance with state and federal laws, requirements, and/or regulations.

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

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.