STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 09/25/2025 for all previous deficiencies identified on 07/22/2025, of the Main Building (building 1). Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 1998. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the Alzheimer building (SCU). The facility had a total capacity of 103 certified Medicare and Medicaid beds with a census of 74 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		12/03/2025
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any	K0353	The five-year internal inspection documentation was not available at the time of survey. On 10/6/2025, the fire and safety company we are contracted with completed the required five-year internal inspection. Since this deficiency had the potential to affect the entire facility, the Maintenance Manager conducted a review of sprinkler system inspection records on 9/26/2025. No additional overdue internal inspections were identified. Maintenance staff were educated on documentation requirements for the sprinkler system maintenance and testing. Facility is contracted with a fire and safety company to perform required inspections. All sprinkler system testing and maintenance records will be stored in the Life Safety binder kept in a secure but easily accessible location for regulatory review. The five-year Sprinkler System maintenance and testing will be added to the monthly QAPI agenda to include the	10/06/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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

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K0353 SS = E	Continued from page 1 non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, document review and staff interview, the facility failed to maintain and provide documentation of required maintenance for the water-based fire protection systems in accordance with 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency could affect the entire fire sprinkler system. The deficiency could affect all residents, staff, and volunteers at the facility. The findings were: Document review on 09/25/2025 at 12:35 PM revealed the facility failed to provide documentation of testing and maintenance for Water-Based Fire Protection Systems at building 1 in accordance with 2011 NFPA 25. The facility failed to provide documentation for testing of the following fire automatic sprinkler systems: a) Five-year internal inspection of piping and branch line conditions - 14.2 Interview with the facility maintenance manager at the time of the observation acknowledged the deficiencies. Interview with the facility maintenance manager and the facility administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5 2010, NFPA 25, Sections 5.2.2.2, 14.2	K0353	Continued from page 1 next five year testing due date to ensure maintenance director is aware of due date to be in contact with contracted company to perform testing.	
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K0761	Upon identification of the deficiency, the facility completed a full, compliant annual fire door inspection for all fire-rated doors. A comprehensive fire door inventory list was created and finalized on 9/30/2025. Inspection findings and documentation have been placed in the Life Safety Code Compliance Binder. A facility-wide review was completed on 9/26/2025 by the Maintenance Manager, and no additional areas were found lacking an inventory list or required documentation. Any missing paperwork was updated and	10/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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K0761 SS = F Bldg. 01	Continued from page 2 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of an annual maintenance, inspection, and testing program for fire doors at building 1 in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 80, Standard for Fire Doors and Other Operating Protectives. The deficiency affected all fire doors. Failure to inspect, test, and maintain fire doors could result in injury or death in the event of a fire. The deficiency could impact all residents, staff, and visitors. The findings were: Document review on 09/25/2025 at 1:15 PM revealed the facility failed to provide documentation of annual maintenance, inspection and testing of all fire doors at building 1. Doors have been inspected, but no inventoried list was created. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections 19.7.6, 4.6.12, 7.2.1.15.2, 2010 NFPA 80, Section 5.2.1	K0761	Continued from page 2 consolidated in the Life Safety binder. A Fire Door Master Inventory List has been permanently implemented. The facility created a Fire Door Inspection & Testing Schedule as per TELS. All maintenance staff were re-trained on annual inspection requirements, recordkeeping expectations, and how to maintain the master inventory list. The Administrator and Maintenance Manager will maintain all fire door records in a centralized Life Safety Code binder, ensuring records are secure and readily available for surveyors. The Maintenance Manager or designee will perform a monthly audit verifying the fire door inventory list is complete; annual inspection dates are current; documentation is properly filed and accessible. Audit findings will be reviewed monthly in QAPI Committee meetings. Monitoring will continue for 12 months, or until the QAPI Committee determines sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ALZHEIMERS BUIL.. B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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

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K0000	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 09/25/2025 for all deficiencies identified on 07/22/2025, of the Alzheimer's Building (building 2). Requirements for Long Term Care Facilities Section 42 CFR 483.90 except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building of Type V (111) construction built in 2008. The building was equipped with a supervised, automatic wet sprinkler system with a dry branch, and an addressable fire alarm system that communicated with the Main building (NH). The facility had a total capacity of 103 certified Medicare and Medicaid beds with a census of 74 residents. The findings that follow demonstrate noncompliance with 42 CFR 483.90.	K0000		12/03/2025
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any	K0353	The five-year internal inspection documentation was not available at the time of survey. On 10/6/2025, the fire and safety company we are contracted with completed the required five-year internal inspection. Since this deficiency had the potential to affect the entire facility, the Maintenance Manager conducted a review of sprinkler system inspection records on 9/26/2025. No additional overdue internal inspections were identified. Maintenance staff were educated on documentation requirements for the sprinkler system maintenance and testing. Facility is contracted with a fire and safety company to perform required inspections. All sprinkler system testing and maintenance records will be stored in the Life Safety binder kept in a secure but easily accessible location for regulatory review. The five-year Sprinkler System maintenance and testing will be added to the monthly QAPI agenda to include the	10/06/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ALZHEIMERS BUIL.. B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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Goshen Healthcare Community	2009 Laramie St , Torrington, Wyoming, 82240

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K0353 SS = D	Continued from page 1 non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide documentation of maintenance for the water-based fire protection systems in accordance with 2012 NFPA 101, Life Safety Code, and 2011 NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Failure to test and maintain water-based fire protection systems could result in injury or death in the event of a fire. The deficiency could affect the entire fire sprinkler system. The deficiency could affect all residents, staff, and volunteers at the facility. The findings were: Document review on 09/25/2025 at 12:35 PM revealed the facility failed to provide documentation of testing and maintenance for Water-Based Fire Protection Systems at building 2 in accordance with 2011 NFPA 25. The facility failed to provide documentation for testing of the following fire automatic sprinkler systems: a) Five-year internal inspection of piping and branch line conditions Interview with the facility maintenance manager at the time of the observation acknowledged the deficiencies. Interview with the facility maintenance manager and the administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101, Section 9.7.5, 2010 NFPA 25, Section 14.2	K0353	Continued from page 1 next five year testing due date to ensure maintenance director is aware of due date to be in contact with contracted company to perform testing.	
K0761 SS = F Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing	K0761	Upon identification of the deficiency, the facility completed a full, compliant annual fire door inspection for all fire-rated doors. A comprehensive fire door inventory list was created and finalized on 9/30/2025. Inspection findings and documentation have been placed in the Life Safety Code Compliance Binder. A facility-wide review was completed on 9/26/2025 by the Maintenance Manager, and no additional areas were found lacking an inventory list or required documentation. Any missing paperwork was updated and consolidated in the Life Safety binder.	10/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535057	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ALZHEIMERS BUIL.. B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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K0761 SS = F Bldg. 02	Continued from page 2 possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on document review and staff interview, the facility failed to provide evidence of an annual maintenance, inspection, and testing program for fire doors at building 2 in accordance with 2012 NFPA 101, Life Safety Code, and 2010 NFPA 80, Standard for Fire Doors and Other Operating Protectives. The deficiency affected all fire doors. Failure to inspect, test, and maintain fire doors could result in injury or death in the event of a fire. The deficiency could impact all residents, staff, and visitors. The findings were: Document review on 09/25/2025 starting at 1:15 PM revealed the facility failed to provide documentation of annual maintenance, inspection and testing of all fire doors at building 2. Doors have been inspected, but no inventoried list was created. Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency. Interview with the facility maintenance manager and the administrator at the time of exit confirmed the deficiency. REF: 2012 NFPA 101 Sections 19.7.6, 4.6.12, 7.2.1.15.2, 2010 NFPA 80, Section 5.2.1	K0761	Continued from page 2 A Fire Door Master Inventory List has been permanently implemented. The facility created a Fire Door Inspection & Testing Schedule as per TELS. All maintenance staff were re-trained on annual inspection requirements, recordkeeping expectations, and how to maintain the master inventory list. The Administrator and Maintenance Manager will maintain all fire door records in a centralized Life Safety Code binder, ensuring records are secure and readily available for surveyors. The Maintenance Manager or designee will perform a monthly audit verifying the fire door inventory list is complete; annual inspection dates are current; documentation is properly filed and accessible. Audit findings will be reviewed monthly in QAPI Committee meetings. Monitoring will continue for 12 months, or until the QAPI Committee determines sustained compliance.	

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 12/03/2025

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

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E0000	Initial Comments An Emergency Preparedness revisit survey was conducted by Healthcare Licensing and Surveys on 09/25/2025, the facility is in compliance.	E0000		12/03/2025

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