DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0043	A. BUILDING _____ B. WING _____	C 07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1326 SAGE STREET ROCK SPRINGS, WY 82901

(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
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs - Activities of Daily Living BIMS - Brief Interview for Mental Status CNA - Certified Nurse Aide IDT - Interdisciplinary Team MAR - Medication Administration Record MDS - Minimum Data Set POA - Power of Attorney PRN - Pro re nata (as needed) TAR - Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Elliott — TITLE: Executive Director — (X6) DATE: 8/18/15

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.

AUG 18 2015
Healthcare Licensing and Surveys

OVER

8/18/15

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F 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interview, the facility failed to contact the resident's physician about a change in the resident's condition for 2 of 3 sample residents (#4, #35) with a change in condition. The findings were: 1. Review of the face sheet for resident #35 revealed the resident had diagnoses that included dementia with behavior disturbance, diabetes mellitus, generalized pain, and constipation. The following concerns were identified: a. Interview with a family member on 7/30/15 at 9:20 AM revealed the resident began to have increased behaviors at the end of May, 2015 when the facility moved the resident to a different room. Additionally, the family member revealed the resident's vision was very impaired. b. Review of the nursing note dated 5/27/15, timed 2:15 PM, showed "Resident transferred from 300 hall to Frontier hall room [room number]. Confused about change. Keeps wandering to front and talking with nurse. Re-directed to [room number]. Explained that this	F 157	**F157 483.10 10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** It is the intent of the facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. 1 Resident #35 no longer resides within the facility. Resident #35 family was contacted before and room move was discussed before it happened. An in-service conducted with facility LN staff regarding notification to physician of a change of condition on 8/10/15. DON or designee will audit the 24hr alert charting books weekly to assure changes in condition are reported to physician. 2. Resident #4 was reassessed for change in condition and physician notified of current status and plan of care updated. In-service conducted with facility LN staff regarding notification to physician of a change of condition on 8/10/15. DON or designee will audit the 24hr alert charting books weekly to assure changes in condition are reported to physician. 8/10/15.	8/12/15

8/18/15 - This POC accepted between Melissa Elliott, Executive Director and Tony Madden Surveyor with a DOC for all Tags 8/18/15. slbk

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F 157	Continued From page 2 was [his/her] new room. Res [resident] expressed items were missing will continue to monitor." c. Review of the nursing note dated 5/27/15, timed 9:30 PM, showed "Rt [resident] had a room change today to [room number]. Rt [resident] had an increase in behaviors. [S/he] hit another rt [resident] in the back of [his/her] head. No injury noted to rt [resident]...[Resident] fretted and was confused, upset, "scared" of [his/her] new surroundings myself and other C.N.A.'s (sic)..." d. Review of the "Determining Cause of Disruptive Behavior" form dated 5/27/15 showed the resident hit another resident. Possible triggers for the resident's behavior were listed as "confused due to room change." e. Review of the nursing note dated 5/29/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and agitated over room change and roommate. Continually redirecting and assisting res [resident] with ADLs. PRN ativan given. Resident continues to wander, ask questions, require assistance with tasks res [resident] can accomplish indep [independently] ex [example]: opening bathroom door, finding room, looking for clothes, etc..." f. Review of the nursing note dated 5/30/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and easily agitated tonight. Obsessive re: toilet paper. Requires constant redirection. Res [resident] put socks in toilet, kept finding rolls of toilet paper and taking to room. PRN ativan given..." g. Review of nursing notes showed the resident refused a shower on 6/11/15, 6/12/15, and 6/15/15 and was leaving large amounts of toilet paper and stool in the toilet that were causing the toilet to be plugged. h. Review of the nursing note dated 6/30/15, timed 11 PM, showed the resident had been	F 157	DON or designee will audit the 24hr alert charting books weekly to assure changes in condition are reported to physician. An audit of the 24 hour alert charting was conducted to assure residents with a change in condition physician was notified and documentation made in the medical record. Trends identifies will be reported to the QAPI meeting monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be completed by August 18, 2015.	8/18/15

8/18/15 JN

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F 157	Continued From page 3 wandering the facility hallways, "looking for [his/her] room" and when passing another resident in the hallway, hit that resident on the back of the head with an open hand. i. Review of the "Determining Cause of Disruptive Behavior" form dated 6/30/15 showed the resident hit another resident on the back of the head. Possible triggers for the disruptive behavior were described as "Has been very moody and aggressive last couple days. Unknown cause." j. Review of the medical record showed no evidence the resident's physician was contacted regarding the resident's increased behaviors and difficulty in adjusting to a new room. k. Interview with the administrator, DON and regional director of clinical services on 7/30/15 beginning at 3:45 PM failed to reveal any evidence the resident's physician was contacted about his/her change in condition. 2. Review of the face sheet showed resident #4 was admitted to the facility on 5/19/15 with diagnoses that included Alzheimer's disease, dementia with behaviors, generalized pain, anxiety, and depression. Review of the resident progress note dated 7/7/15, untimed, showed the resident was discharged to a behavioral health facility on that date due to increased behaviors. The following concerns were identified: a. Review of a resident progress note dated 7/7/15, untimed, showed the facility attempted to contact the resident's POA by phone beginning 7/2/15 "regarding possible transfer to temporary care setting," and received a call from the resident's POA at "about 0915" (9:15 AM) on 7/7/15 with verbal permission to transfer the resident. There was no documentation in the medical record to show the resident's physician	F 157		8/13/15

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F 157	Continued From page 4 was notified of the transfer from the facility. b. Interview with the administrator on 7/30/15 beginning at 3:48 PM revealed the facility had a discussion with the physician "way back" to send the resident to a facility in another state, but she was unable to produce evidence the physician was consulted regarding the 7/7/15 transfer to the behavioral health facility.	F 157		
F 202 SS=E	483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident report review, and staff interview, the facility failed to document the circumstances of resident transfer in the clinical record for 2 of 3 sample residents (#4, #35) who were transferred. The findings were: 1. Review of the face sheet for resident #35 revealed the resident had diagnoses that included dementia with behavior disturbance, diabetes mellitus, generalized pain, and constipation. The following concerns were identified: a. Interview with a family member on 7/30/15	F 202	F 202 483.12 (a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RESIDENTS It is the intent of the facility to document the circumstances of resident transfer or discharge in the clinical record. 1. Resident #35 is no longer in the facility. An in-service was provided to LN staff at facility in regards to documentation in the clinical record and notification to the resident's physician where there has been a decision made to transfer. This in-service was conducted on 8/10/15.	8/18/15

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F 202	Continued From page 5 at 9:20 AM revealed the resident began to have increased behaviors at the end of May, 2015 when the facility moved the resident to a different room. Additionally, the family member revealed the resident's vision was very impaired. b. Review of the nursing note dated 5/27/15, timed 2:15 PM, showed "Resident transferred from 300 hall to Frontier hall room [room number]. Confused about change. Keeps wandering to front and talking with nurse. Re-directed to [room number]. Explained that this was [his/her] new room. Res [resident] expressed items were missing will continue to monitor." c. Review of the nursing note dated 5/27/15, timed 9:30 PM, showed "Rt [resident] had a room change today to [room number]. Rt [resident] had an increase in behaviors. [S/he] hit another rt [resident] in the back of [his/her] head. No injury noted to rt [resident]...[Resident] fretted and was confused, upset, "scared" of [his/her] new surroundings myself and other C.N.A.'s (sic)..." d. Review of the "Determining Cause of Disruptive Behavior" form dated 5/27/15 showed the resident hit another resident. Possible triggers for the resident's behavior were listed as "confused due to room change." e. Review of the nursing note dated 5/29/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and agitated over room change and roommate. Continually redirecting and assisting res [resident] with ADLs. PRN ativan given. Resident continues to wander, ask questions, require assistance with tasks res [resident] can accomplish indep [independently] ex [example]: opening bathroom door, finding room, looking for clothes, etc..." f. Review of the nursing note dated 5/30/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and easily agitated tonight.	F 202		8/18/15

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F 202	Continued From page 6 Obsessive re: toilet paper. Requires constant redirection. Res [resident] put socks in toilet, kept finding rolls of toilet paper and taking to room. PRN ativan given..." g. Review of nursing notes showed the resident refused a shower on 6/11/15, 6/12/15, and 6/15/15 and was leaving large amounts of toilet paper and stool in the toilet that were causing the toilet to be plugged. h. Review of the nursing note dated 6/30/15, timed 11 PM, showed the resident had been wandering the facility hallways, "looking for [his/her] room" and when passing another resident in the hallway, hit that resident on the back of the head with an open hand. i. Review of the "Determining Cause of Disruptive Behavior" form dated 6/30/15 showed the resident hit another resident on the back of the head. Possible triggers for the disruptive behavior were described as "Has been very moody and aggressive last couple days. Unknown cause." j. Review of the medical record showed no evidence the resident's physician was contacted regarding the resident's increased behaviors and difficulty in adjusting to a new room. k. Interview with the DON on 7/29/15 at 4 PM revealed a care plan had not yet been developed for the resident by the new corporation, and the facility had been basing care for the resident on the care plan developed by the previous facility. Review of that care plan, with a print date of 1/8/15, showed no changes in interventions in response to the resident's increased behaviors after the room change. l. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors.	F 202		8/18/15

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F 202	Continued From page 7 m. Further review of the medical record showed no nursing notes were made after 7/1/15. There was no documentation of the resident's transfer or the need for transfer. n. Review of the incident report dated 7/17/15 showed the resident returned to the facility on 7/17/15 and was sent to another facility soon after that same day. However, review of the clinical record showed no documentation on the resident after 7/1/15, and no documentation to indicate the need for the resident to be transferred again on 7/17/15 to another facility. 2. Review of the face sheet showed resident #4 was admitted to the facility on 5/19/15 with diagnoses that included Alzheimer's disease, dementia with behaviors, generalized pain, anxiety, and depression. Review of the resident progress note dated 7/7/15, untimed, showed the resident was discharged to a behavioral health facility on that date due to increased behaviors. The following concerns were identified: a. Review of a resident progress note dated 7/7/15, untimed, showed the facility attempted to contact the resident's POA by phone beginning 7/2/15 regarding "possible transfer to temporary care setting," and received a call from the POA at "about 0915 [9:15 AM]" on 7/7/15 with verbal permission to transfer the resident. There was no documentation in the nurse's notes to show the resident's physician was involved in the discharge from the facility. b. Review of the physician notes for resident #4 showed the most recent note was dated 5/20/15, with no mention of transferring the resident to a behavioral health facility. c. Interview with the administrator on 7/30/15 beginning at 3:48 PM revealed facility staff had a discussion with the physician "way back" to send	F 202	2. Resident #4 has be reassessed for behavior and plan of care updated. In-service was provided to LN staff at facility in regards to documentation in the clinical record and notification to the resident's physician where there has been a decision made to transfer. This in-service was conducted on 8/10/15. An audit of discharges has been conducted to identify missing documentation for other discharged residents. Medical Records or designee will audit discharge records weekly to assure documentation is in the records regarding circumstances surrounding the discharge. Trends identifies will be reported to the QAPI meeting monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be completed by August 18, 2015.	8/18/15

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F 202	Continued From page 8 the resident to a different facility in Utah, but she was unable to produce any evidence the physician was involved in the 7/7/15 transfer to the behavioral health facility.	F 202		
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer	F 203	F 203 483.12(a)(4)-(6) NOTICE REQUIRMENTS BEFORE TRANSFER/DISCHARGE It is the intent of the facility to notify in writing the resident or residents POA of transfer and reason for transfer. 1. Resident #35 is no longer in the facility. An in-service to LN and Administrative staff was conducted on 8/10/15 in regards to providing residents or their POA with the required bed hold policy.	8/18/15

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F 203	Continued From page 9 or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review, family interview, and staff interview, the facility failed to properly notify, in writing, the resident's POA of resident transfer and the reasons for the transfer for 2 of 3 sample residents (#4, #36) who were transferred to another facility. The findings were: 1. Review of the face sheet for resident #35 revealed the resident had diagnoses that included dementia with behavior disturbance, diabetes mellitus, generalized pain, and constipation. The following concerns were identified: a. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors. b. Further review of the medical record showed no nursing notes were made after 7/1/15. There was no documentation of the resident's	F 203	2. Resident #4 has been reassessed for discharge need and there is no current plan for discharge. In-service to LN and Administrative staff was conducted on 8/10/15 in regards to providing residents or their POA with the required notice in writing. An audit of discharges from 5/19/15 from facility has been conducted to identify other residents who had POA's not notified in writing. An audit will be conducted weekly by the ED or designee on all discharges to assure notice was given in writing. Trends identified will be reported to the QAPI meeting monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be completed by August 18, 2015.	8/18/15

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SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 203	Continued From page 11 showed the facility attempted to contact the resident's power of attorney (POA) by phone beginning 7/2/15 "regarding possible transfer to temporary care setting," and received a call from the POA at "about 0915" (9:15 AM) on 7/7/15 with verbal permission to transfer the resident. There was no evidence of written notice for this discharge. b. Interview with the administrator on 7/30/15 beginning at 3:45 PM confirmed the facility notified the resident's POA via telephone and not in written form, regarding the transfer to the behavioral health facility. c. Review of two discharge notices issued to the POA of resident #4, dated 6/13/15 and 7/17/15, showed instructions were provided should the resident or POA have wanted to appeal the decision to transfer. However, the contact information provided was for the Washington State Office of Administrative Hearings, and not the Wyoming Office of Healthcare Licensing and Surveys. Interview with the administrator and regional director of clinical services on 7/30/15 beginning at 3:45 PM confirmed the contact information provided in the discharge notices was incorrect.	F 203		8/18/15
F 205 SS=E	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold	F 205		

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F 203	Continued From page 10 transfer or the need for transfer. No transfer or discharge notices were found. c. Review of the incident report dated 7/17/15 showed the resident returned to the facility on 7/17/15 and was sent to another facility soon after that day. However, review of the clinical record showed no documentation on the resident after 7/1/15, and no documentation to indicate the need for the resident to be transferred again on 7/17/15 to another facility. d. Interview with a family member on 7/30/15 at 9:20 AM revealed the family member held the resident's power of attorney, but had not received the required discharge notice with the required items for either of the resident's discharges from the facility in July, 2015. e. Interview with the administrator, DON, and regional director of clinical services on 7/30/15 at 3:45 PM revealed the facility had not completed the required discharge steps due to being unaware of the policy and procedure for discharges. 2. Review of the face sheet showed resident #4 was admitted to the facility on 5/19/15 with diagnoses that included Alzheimer's disease, dementia with behaviors, generalized pain, anxiety, and depression. Review of the 7/7/15 nurse's note showed the resident was temporarily discharged to a behavioral health facility on 7/7/15. Review of the Nursing Admission Evaluation showed the resident was readmitted to the facility on 7/17/15. The following concerns were identified: a. Review of the resident progress note dated 7/7/15, untimed, showed the resident was discharged to a behavioral health facility on that date due to increased behaviors. Review of a resident progress note dated 7/7/15, untimed,	F 203	**F205 483.12 (b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFER** It is the intent of this facility to provide written information to the resident's legal representative that specifies the duration of the facilities bed hold policy. 1. Resident #35 is no longer in the facility. An in-service to LN and Administrative staff was conducted on 8/10/15 in regards to providing residents or their POA with the required bed hold policy. 8/18/15	

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F 205	Continued From page 12 periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review, family interview and staff interview, the facility failed to provide written information to the resident's legal representative that specified the duration of the facility's bed hold policy for 2 of 3 discharges (#28, #35). The findings were: 1. Review of the face sheet for resident #35 revealed the resident had diagnoses that included dementia with behavior disturbance, diabetes mellitus, hypertension, generalized pain, and constipation. The following concerns were identified: a. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors. b. Further review of the medical record showed no nursing notes were made after 7/1/15. There was no documentation of the resident's transfer or the need for transfer. No transfer or discharge notices were found. c. Review of the incident report dated 7/17/15 showed the resident returned to the facility on 7/17/15 and was sent to another facility soon	F 205	2. Resident #28 never received bed hold policy. In-service to LN and Administrative staff was conducted on 8/10/15 in regards to providing residents or their POA with the required bed hold policy. 3. In-service to LN and Administrative staff was conducted on 8/10/15 in regards to providing residents or their POA with the required bed hold policy. An audit of discharges since 5/19/15 has been conducted to identify others that have not been notified of bed hold policy. Medical Records or designee will conduct a weekly audit of discharged residents to assure bed hold notice was given. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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F 205	Continued From page 13 after. However, review of the clinical record showed no documentation on the resident after 7/1/15, and no documentation to indicate the need for the resident to be transferred again on 7/17/15 to another facility. d. Interview with a family member on 7/30/15 at 9:20 AM revealed the family member held the resident's power of attorney, but had not received any bed hold information from the facility for either discharge. 2. Review of the medical record for resident #28 showed the resident was discharged to an acute care facility on 7/7/15. Continued review showed there was no evidence of written notification for the duration of the bed-hold policy provided to the resident and or family member or legal guardian. 3. Interview with the administrator, DON, and regional director of clinical services on 7/30/15 beginning at 3:45 PM revealed the facility had not completed the required discharge steps due to being unaware of the policy and procedure for discharges.	F 205		8/18/15
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225	**F225 483.13 (c)(1)(ii)-(iii), (c)(2) – (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** It is the intent of the facility to document and investigate any events involving allegations of mistreatment, neglect, abuse, injuries of unknown source and	

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F 225	Continued From page 14 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of state survey agency incident logs, and staff interview, the facility failed to investigate and report an allegation of abuse for 1 of 5 incidents reviewed (#4). The findings were: 1. Review of the nursing note dated 6/15/15 (late entry) showed a CNA reported that resident #4 was "caught holding both the arms of another resident" and the other resident "was screaming for help [and] crying." No injuries were noted.	F 225	misappropriation of resident property in accordance with state and federal regulatory requirements. 1. Resident #4 has been re-assessed for abusive behavior and plan of care updated. An in-service for facility staff has been conducted on 8/10/15 regarding the abuse reporting requirements. 2. An in-service for facility staff has been conducted on 8/10/15 regarding the abuse reporting requirements. 3. An in-service for facility staff has been conducted on 8/10/15 regarding the abuse reporting requirements. An audit of incident reports from 5/19/15 forward has been conducted to assure that allegations of abuse have been reported. The ED or designee will audit the 24 hour alert charting log and the incident log weekly to assure allegations of abuse are reported timely. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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F 225	Continued From page 15 2. Review of the state survey agency incident log on 7/29/15 did not show the allegation had been reported to the state survey agency. 3. Interview with the administrator on 7/30/15 at 10:38 AM revealed she was unaware of the allegation, and was opening an investigation into the allegation at that time.	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 3 of 4 resident hallways. The findings were: 1. Observation of the floor in the hallway near room 306 on 7/30/15 at 2:10 PM showed there were 10 tiles measuring 12 inches x 12 inches that were cracked. 2. Observation of the "Aspen Room" floor on 7/30/15 at 2:14 PM showed there were 18 tiles measuring 12 inches x 12 inches that were cracked. 3. Observation of the floor outside the chemical storage area on 7/30/15 at 2:16 PM showed there were 10 tiles measuring 12 inches x 12 inches that were cracked.	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES It is the intent of this facility to provide a sanitary and well maintained environment. 1. The 10 floor tiles in the hallway near room 306 have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 2. The 18 floor tiles in the "Aspen Room" have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 3. The 10 floor tiles outside the chemical storage area have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted	8/18/15

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F 253	Continued From page 16 4. Observation of the floor outside room 406 on 7/30/15 at 2:22 PM showed there were 9 tiles measuring 12 inches x 12 inches that were cracked. Continued observation at that time showed 13 tiles measuring 12 inches x 12 inches that were cracked outside of room 407. 5. Observation of the floor in the "Antelope Aly" sitting area on 7/30/15 at 2:25 PM showed 5 tiles measuring 12 inches x 12 inches that were cracked. Continued observation at that time showed 3 tiles measuring 12 inches x 12 inches that were cracked outside the dirty utility room. 6. Observation of the floor between room 414 and room 416 on 7/30/15 at 2:30 PM showed there were 9 tiles measuring 12 inches x 12 inches that were cracked. 7. Observation of the floor near the oxygen storage exit on 7/30/15 at 2:35 PM showed 4 tiles measuring 12 inches x 12 inches and 5 tiles measuring 7 inches x 12 inches that were cracked or broken. 8. Observation of the shower room on the rehab west hall on 7/30/15 at 2:45 PM showed there were gaps between the tiles that measured 46 inches in length, where the water flowed between them, and which could not be effectively cleaned. 9. Observation of the hall outside room 402 on 7/30/15 at 2:18 PM showed the vent cover was off and sharp metal edges were exposed. 10. Observation of room 407 on 7/30/15 at 2:20 PM showed the wall had damage to the corners near the bathroom. Area #1 was four inches from	F 253	on 8/10/15. 4. The 9 floor tiles outside room 406 and the 13 floor tiles outside room 407 have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 5. The 5 floor tiles in the sitting are near "Antelope Aly" and the 3 tiles near the dirty utility room have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 6. The 9 floor tiles between room 414 and room 416 have been replaced. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 7. The 4 floor tiles near the oxygen storage area measuring 12 inches x 12 inches and the 5 floor tiles measuring 7 inches x 12 inches have been replaced. An in-service to facility staff on reporting areas of repair to maintenance was conducted on 8/10/15. 8. The shower room on the rehab west hall has been taken out of service. 9. Vent has been repaired. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15.	8/18/15

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F 253	Continued From page 17 the floor and measured 28 inches in length, with exposed metal and underlying drywall. Area #2 was four inches from the floor and measured 18 inches in length, with exposed metal and underlying drywall. Continued observation at that time showed a hole in the wall behind the empty bed closest to the entry door. The hole measured 13 inches by 5 1/2 inches. 11. Observation of room 411 on 7/30/15 at 2:28 PM showed the wall had damage to the corners near the bathroom. Area #1 was four inches from the floor and measured 19 inches in length, with exposed metal and underlying drywall. Area #2 started at the floor and measured 23 inches in length, with exposed metal and underlying drywall. 12. Interview with the administrator on 7/30/15 at 8:45 AM showed there was a plan to remodel the facility; however, there was no documented timeline for correction. 13. Interview with the maintenance director on 7/30/15 at 2:50 PM confirmed the areas were damaged and because of the damage the facility would not be able to effectively clean the tiles, the damaged walls, or the shower room.	F 253	10. All damaged noted in room 407 has been repaired. An in-service to facility staff on reporting areas of repair to maintenance was conducted on 8/10/15. 11. All damaged noted in room 411 has been repaired. An in-service to facility staff on reporting areas of needed repair to maintenance was conducted on 8/10/15. 12. The shower room on the west rehab hall has been taken out of service. 13. The shower room on the west rehab hall has been taken out of service. Grand rounds have been completed to identify other areas in need of repair. A complete renovation is planned. ED or designee will conduct weekly rounds to identify further potential environmental issues. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 18 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, family interview and staff interview the facility failed to develop a plan of care for behaviors for 3 of 3 sample residents with behaviors (#4, #28, #35). The findings were: 1. Review of the face sheet showed resident #35 had diagnoses that included dementia with behavior disturbance, diabetes mellitus, hypertension, generalized pain, and constipation. The following concerns were identified: a. Interview with a family member on 7/30/15 at 9:20 AM, revealed the resident began to have increased behaviors at the end of May, 2015, when the facility moved the resident to a different room. Additionally, the family member revealed the resident's vision was very impaired. b. Review of the nursing note dated 5/27/15, timed 2:15 PM, showed "Resident transferred from 300 hall to Frontier hall room [room number]. Confused about change. Keeps wandering to front and talking with nurse.	F 279	**F279 483.2(d), 483.20(k)(1)** **DEVELOP COMPREHENSIVE CARE PLANS** It is the intent of this facility to develop a plan of care for behaviors that is individual to each resident's needs. 1. Resident #35 no longer resides in the facility. 2. Resident #28 reassessed and care plan has been updated. Social Services and LN staff have been in-serviced on the importance of behavioral care planning and behavior management and facility staff has been in-serviced on documenting behaviors. staff has been in-serviced on documenting behaviors. 3.Resident #4 has been reassessed and care plan has been updated.. Social Services and LN staff have been in-serviced on the importance of behavioral care planning and behavior management and facility staff has been in-serviced on documenting behaviors..	8/18/15

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F 279	Continued From page 19 Re-directed to [room number]. Explained that this was [his/her] new room. Res [resident] expressed items were missing will continue to monitor." c. Review of the nursing note dated 5/27/15, timed 9:30 PM, showed "Rt [resident] had a room change today to [room number]. Rt [resident] had an increase in behaviors. [S/he] hit another rt [resident] in the back of [his/her] head. No injury noted to rt [resident]...[Resident] fretted and was confused, upset, "scared" of [his/her] new surroundings myself and other C.N.A.'s (sic)..." d. Review of the "Determining Cause of Disruptive Behavior" form dated 5/27/15 showed the resident hit another resident. Possible triggers for the resident's behavior were listed as "confused due to room change." e. Review of the nursing note dated 5/29/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and agitated over room change and roommate. Continually redirecting and assisting res [resident] with ADLs. PRN ativan given. Resident continues to wander, ask questions, require assistance with tasks res [resident] can accomplish indep [independently] ex [example]: opening bathroom door, finding room, looking for clothes, etc..." f. Review of the nursing note dated 5/30/15, timed "NOC" [night shift] showed, "Res [resident] remains confused and easily agitated tonight. Obsessive re: toilet paper. Requires constant redirection. Res [resident] put socks in toilet, kept finding rolls of toilet paper and taking to room. PRN ativan given..." g. Review of the IDT note dated 6/3/15, untimed, showed "[Resident] is in an "okay" mood today. Res [resident] is on ativan and depakote for dementia and behaviors. [His/her] BIMS score is 11. [S/he] has a hard time sleeping and is often feeling restless. [Resident name] often has	F 279	4. Social Services and LN staff have been in-serviced on the importance of behavioral care planning and behavior management and facility staff has been in-serviced on documenting behaviors. An audit of the 24 hour alert charting log and the behavior monitoring sheets has been completed to assure residents with behaviors have a plan of care in place. An audit of the behavior monitoring sheets and the 24 hour alert charting log will be conducted weekly by the Social Services Director or designee to assure residents with behaviors have a plan of care. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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SAGE VIEW CARE CENTER	1328 SAGE STREET ROCK SPRINGS, WY 82901

(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
F 279	Continued From page 20 wandering tendencies which puts (sic) no one at risk. [S/he] has a habit of taking toilet paper out of other resident's rooms. [Resident name] is independent with ADLs. [S/he] sometimes needs to be pointed in the right direction of where to go when [s/he] gets turned around. [S/he] has bad eyesight and wears glasses..." There was no analysis of the resident's agitation, and no recommendations for interventions to assist the resident in adapting to new surroundings. h. Review of nursing notes showed the resident refused a shower on 6/11/15, 6/12/15, and 6/15/15 and was leaving large amounts of toilet paper and stool in the toilet that were causing the toilet to be plugged. i. Review of the nursing note dated 6/30/15, timed 11 PM, showed the resident had been wandering the facility hallways, "looking for [his/her] room" and when passing another resident in the hallway, hit that resident on the back of the head with an open hand. j. Review of the "Determining Cause of Disruptive Behavior" form dated 6/30/15 showed the resident hit another resident on the back of the head. Possible triggers for the disruptive behavior were described as "Has been very moody and aggressive last couple days. Unknown cause." k. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors. l. Interview with the DON on 7/29/15 at 4 PM revealed a care plan had not yet been developed for the resident by the new corporation, and the facility had been basing care for the resident on the care plan developed by the former owners. Review of that care plan, with a print date of 1/8/15, showed no changes in interventions in	F 279		8/18/15

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F 279	Continued From page 21 response to the resident's increased behaviors after the room change. 2. Review of the activities care plan showed resident #28 had diagnoses that included anxiety, dementia with behavior disturbances, depressive disorder, epilepsy, and persistent insomnia. Review of the nurse's notes showed the resident was temporarily discharged to a behavioral health facility on 7/7/15 due to behaviors, violent outbursts, and hitting other residents. The resident was re-admitted to the facility on 7/17/15. The following concerns were identified: a. Review of a nurse's note dated 7/17/15, timed for the "NOC [night]" shift, showed the resident was wandering until approximately 2 AM. A wandergard was placed on the resident's right ankle. The resident attempted "numerous times" to leave the facility out the "back door by O2 [oxygen] tanks." b. Review of a nurse's note dated 7/18/15, timed for the "NOC" shift, showed the resident was wandering the "majority of the shift." Continued review showed the resident was found urinating "throughout building" and going into other resident's rooms "causing agitation to other residents." c. Review of a nurse's note dated 7/19/15, timed for the "NOC" shift, showed the resident was "wandering halls and other resident rooms. Verbalizes (a) desire to leave." Further review showed the resident requires "constant cues to urinate in bathroom, not hallways, dining room, other res. room etc." d. Review of nurse's notes dated 7/20/15, timed 5:30 PM, showed the resident was observed urinating in the dining room and hallway. e. Review of nurse's note dated 7/28/15,	F 279		8/18/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1326 SAGE STREET ROCK SPRINGS, WY 82901

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F 279	Continued From page 22 timed for the "NOC" shift, showed the resident continued to pace halls and tried to urinate on the floor. f. Review of the care plan dated 7/23/15 showed the facility did not develop interventions to prevent the resident from entering other residents' rooms. Further review showed the only intervention for inappropriate urination was to "check bathroom door throughout the day to make sure it's not locked." Further review showed the facility did not care plan interventions for behaviors, violent outbursts, and hitting other residents, or interventions for behaviors that were previously identified and resulted in discharge on 7/7/15. g. Review of the "Interim Plan of Care" that was undated showed the resident was independent with toileting and required "occasional staff check." Further review of the behavior section showed the resident was irritable, confused, and forgetful; however, no interventions were identified. 3. Review of the face sheet for resident #4 showed an admission date of 5/19/15, with diagnoses that included Alzheimer's disease, dementia with behaviors, cerebrovascular accident (CVA - stroke), delusions, and psychosis. Review of the nurse's notes showed the resident was temporarily discharged to a behavioral health facility on 7/7/15 due to increased behaviors. Review of the Nursing Admission Evaluation showed the resident was readmitted to the facility on 7/17/15 and indicated the resident's mental status was confused, forgetful, withdrawn, agitated, combative, and sexually inappropriate. The following concerns were identified: a. Review of the nurse's note dated 7/19/15	F 279		8/18/15

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F 279	Continued From page 23 and timed 3:30 PM showed the resident "became combative" and slapped and punched a CNA who was assisting him/her to the toilet. The nurse's note dated 7/22/15 and timed 12 AM showed the resident was "ripping [his/her] bedroom screen apart [with] part of heater vent [s/he] tore off wall," was "abusive and inappropriate with staff," and "was grabbing other female residents." The nurse's note dated 7/22/15 and timed 9:30 PM showed the resident had behaviors including "invading personal space and improper remarks-pregnant staff member was punched by res [resident] as she tried to assist [him/her] to bed." The nurse's note dated 7/25/15 and timed 11 PM showed the resident was "wandering and talking and bothering other resident [sic] and trying to touch staff." b. Interview with CNA #1 on 7/28/15 at 3:20 PM revealed she had not received any training or education regarding the resident's behaviors. She stated that it was "trial and error" and the resident "can be very difficult at times to redirect." c. Interview with CNA #2 on 7/29/15 at 9:35 AM revealed the resident could get aggressive when she tried to provide cares, and that she would leave the resident alone to calm down. She stated she was "afraid sometimes" of resident #4's reaction to other residents. She confirmed she had not received any training or education regarding the resident's behaviors. d. Interview with CNA #3 on 7/30/15 at 8:40 AM revealed she had not received any training regarding the resident's behaviors. She stated it was "trial and error to see what works" regarding the behaviors, and that she found redirection or leaving the resident alone and re-approaching later worked for her. e. Review of the Interim Plan of Care, undated, "Behavioral/ Mental Status" indicated	F 279		8/18/15

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F 279	Continued From page 24 the resident was alert, but the resident was not identified as having behaviors, nor were there interventions in place related to behaviors. f. Interview with the DON on 7/30/15 beginning at 3:45 PM revealed the facility had been using the interim plan of care since admission 4. Interview with the administrator, DON and regional director of clinical services on 7/30/15 beginning at 3:45 PM revealed each episode of resident behaviors was reviewed at the IDT meeting the following day, and the care plan was to be updated as needed.	F 279		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow physician orders for 2 of 10 sample residents (#14, #35), failed to completely document the administration of PRN medications for 3 of 10 sample residents (#4, #6, #11), and failed to accurately transcribe physician orders onto the MAR for 1 of 10 sample residents (#1). The findings were: Regarding physician orders:	F 309	**F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** It is the intent of this facility to follow physician orders and completely document the administration of PRN medications and accurately transcribe physician orders into the MAR. 1. Resident #35 no longer resides in the facility. An audit of current facility medications regimens has been conducted to assure that orders are in accordance with physician's orders, transcribed correctly and documented correctly. An in-service for LN staff was conducted on 8/10/15 regarding physician's orders, transcription and documentations medications.	8/18/15

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F 309	Continued From page 25 1. Review of the face sheet for resident #35 showed s/he had diagnoses that included diabetes mellitus. Review of physician's orders showed an order, with an order date of 2/4/15, for glucose checks to be performed on the resident three times weekly. The following concerns were identified: a. Review of the June, 2015 TAR showed documentation of glucose checks was missing on 6 of the 13 days the checks were supposed to have been done (46%). b. Interview with the DON on 7/29/15 at 4 PM confirmed the glucose checks had not been performed. 2. Review of the 7/8/15 admission MDS assessment showed resident #14 had diagnoses that included lung, brain/spine, and liver cancer. Review of the May, 2015 MAR showed the resident received promethazine HCL (an anti-psychotic and anti-emetic) 25 mg three times daily. Review of the June, 2015 MAR showed the resident received promethazine HCL 25 mg by mouth three times daily from 6/1/15 until 6/7/15, and then received prochlorperazine maleate (an anti-psychotic and anti-emetic) 5 mg by mouth three times daily from 6/8/15 through 6/30/15. The following concerns were identified: a. Review of the physician order recapitulation for May, 2015, signed by the physician on 5/14/15 showed an order for prochlorperazine maleate 5 mg by mouth three times daily. There was no order to administer promethazine HCL 25 mg, and no order to hold the administration of prochlorperazine maleate 5 mg. b. Review of the physician order recapitulation for June, 2015, signed by the	F 309	2. A medication reconciliation has been completed for resident #14 to assure orders are in accordance with physician orders and accurately transcribed. An audit of current facility medications regimens has been conducted to assure that orders are in accordance with physicians orders, transcribed correctly and documented correctly. An in-service for LN staff was conducted on 8/10/15 regarding physicians orders, transcription and documentations medications. . **Regarding the documentation of PRN medication administration:** 1. A medication reconciliation has been completed for resident #11 to assure orders are in accordance with physicians orders and accurately transcribed and PRN documentation prompt available. An in-service for LN staff was conducted on 8/10/15 regarding physicians orders, transcription and documentations medications.	8/18/15

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F 309	Continued From page 26 physician on 6/5/15, showed an order for prochlorperazine maleate 5 mg by mouth three times daily. There was no order to administer promethazine HCL 25 mg, and no order to hold the administration of prochlorperazine maleate 5 mg. c. Interview with DON on 7/29/15 at 2:45 PM confirmed the facility did not have a valid order to administer the promethazine HCL, or to hold the prochlorperazine maleate. Regarding the documentation of PRN medication administration: 1. Review of the 7/8/15 admission MDS assessment showed resident #11 had diagnoses that included depression, anxiety disorder and hypoxemia. Review of the July 2015 physician order recapitulation showed the resident had an order, dated 6/26/15, for Ativan (an anti-anxiety medication) 0.5 mg 1 to 2 tablets three times daily as needed, and an order, dated 7/14/15 for Ativan 1 mg by mouth three times daily as needed. The following concerns were identified: a. Review of the July, 2015 MAR showed between 7/1/15 and 7/14/15 the resident received 13 doses of Ativan, however, there was no documentation to show the reason the medication was administered, whether 1 or 2 tablets had been administered, or whether the administration was effective. b. Further review of the July, 2015 MAR showed between 7/14/15 and 7/27/15 the resident received 14 doses of 1 mg Ativan, however, there was no documentation to show the reason the medication was administered, or whether it was effective. 2. Review of the 7/14/15 admission MDS	F 309	2. A medication reconciliation has been completed from residents #6 anto assure orders are in accordance with physicians orders and accurately transcribed and PRN documentation prompt available. An in-service for LN staff was conducted on 8/10/15 regarding physicians orders, transcription and documentations medications. 3. A medication reconciliation has been completed for residents #4 to assure orders are in accordance with physicians orders and accurately transcribed and PRN documentation prompt available. An in-service for LN staff was conducted on 8/10/15 regarding physicians orders, transcription and documentations medications. 4. An in-service for LN staff was conducted on 8/10/15 regarding physicians orders, transcription and documentations medications. **Regarding the transcription of physician orders onto the MAR:** 1. Medical records and LN staff in-serviced 8/10/15 regarding medication transcription review policy and procedure.	8/18/15

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F 309	Continued From page 27 assessment showed resident #6 had diagnoses that included non-Alzheimer's dementia, mild cognitive impairment, and dementia without behaviors. Review of the July 2015 Physician Order Sheet showed the resident had an order for Xanax (an anti-anxiety medication) 0.25 mg every 8 hours as needed for anxiety. The following concerns were identified: a. Review of the May, 2015 MAR showed the resident received Xanax 10 times, with no evidence of the reason for administration and no documentation of its effectiveness. b. Review of the MAR for June, 2015 showed the resident received Xanax 33 times, with no evidence of the reason for administering the medication, and no documentation of its effectiveness. c. Review of the July 2015 MAR through July 27 showed the resident received Xanax 28 times, with no evidence of the reason for administering the medication and no documentation of its effectiveness. 3. Review of the face sheet for resident #4 showed an admission date of 5/19/15, with diagnoses that included Alzheimer's disease, dementia with behaviors, cerebrovascular accident (stroke), delusions, and psychosis. Review of the MAR for May 2015 showed the resident had an order for "Ativan [an anti-anxiety medication] 1 mg" as needed every hour, up to 3 mg in 3 hours, not to exceed 6 mg per day. The following concerns were identified: a. Review of the May, 2015 MAR showed the resident received Ativan 17 times with no evidence of the reason for administration and no documentation of its effectiveness. b. Review of the June 2015 MAR showed the resident received Ativan 64 times, with no	F 309	An audit of current facility medications regimens has been conducted to assure that orders are in accordance with physicians orders, transcribed correctly and documented correctly. The DON or designee will audit the new TO's and the MAR's weekly to assure transcription and documentation is complete and accurate. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate.	8/18/15

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F 309	Continued From page 28 evidence of the reason for administration and no documentation of its effectiveness. 4. Interview with the administrator, DON and regional director on clinical services on 7/30/15 at 3:45 PM confirmed the expectation that documentation of the administration of PRN medications should include the reason for administration and the effectiveness of the administration. Regarding the transcription of physician orders onto the MAR: 1. Review of the face sheet showed resident #1 was admitted on 7/26/15 from another skilled nursing facility, with diagnoses that included Alzheimer's disease, dementia with behaviors, generalized pain, anxiety, and depression. Admission orders for medications included "Seroquel [an anti-psychotic medication] 12.5 mg 1 [tab] PO Q HS [1 tablet by mouth every night at bedtime], ... acetaminophen 650 mg 1 tab PO TID [1 tablet by mouth three times a day]." The following concerns were identified: a. Review of the July 2015 MAR showed the following handwritten order: "7/26/15 Seroquel 12.5 mg PO q BID PRN" [by mouth two times a day as needed]. The order for "BID" was handwritten over a previous order and made the original order illegible. Review of the July 2015 physician order recapitulation showed the order written as "SEROQUEL F/C 25 mg (1/2 table (12.5 mg)) TABLET Oral" with the frequency indicated as "As Needed Two Times Daily Starting 7/26/15." b. Further review of the July 2015 MAR showed the order for acetaminophen was typed into the MAR as "Tylenol 8 hour 650 mg (1 tab)	F 309		8/18/15

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F 309	Continued From page 29 three times daily." However, the "1 tab" had a handwritten alteration to read "2 tab," equaling 1300 mg per dose, instead of the 650 mg ordered. c. Interview with the DON on 7/30/15 at 5:10 PM confirmed the correct dosage for the medications was the original admission orders. Continued interview at that time revealed the resident had been receiving Seroquel 12.5 mg once daily at bedtime and acetaminophen 325 mg 2 tablets three times a day. The DON also confirmed that the medications were written in the MAR incorrectly, and the MAR should not have been altered by writing over an existing order. Further, it was confirmed the July physician order recapitulation showed an incorrect order for the Seroquel.	F 309		8/18/15
F 314 65=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to implement interventions to promote healing and prevent worsening of a pressure ulcer for 1 of 1 sample residents (#32)	F 314	F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES It is the intent of this facility to implement interventions to promote healing and prevent worsening of pressure ulcers.	

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F 314	Continued From page 30 with a pressure ulcer. The findings were: 1. Review of the 7/9/15 admission MDS assessment showed resident #32 had diagnoses that included cerebrovascular accident, muscle disorder, and generalized pain. Further review showed the resident required the total assistance of 2 or more persons for transferring and the extensive assistance of 1 person for bed mobility, dressing, and personal hygiene and the resident was at risk for pressure ulcers. The following concerns were identified: a. Observation on 7/30/15 at 3:56 PM showed the resident had an open area just below the left buttock, near the ischial tuberosity, that had a bright red center and the edges of the wound appeared white in color. The area was round in shape and approximately the size of a dime. b. Review of the nurse's note dated 7/27/15, timed 1:10 PM, showed the resident had a "dime sized" open area to the left buttock and "paste" was applied. c. Review of the nurse's note dated 7/27/15, timed 5:30 PM, showed the resident was aware of the breakdown to the buttocks area and expressed understanding of the need to reposition and to get up for meals and activities. d. Review of the "Resident Weekly Skin Check Sheet" showed 4 separate weeks of documentation. The "week 2" assessment dated 7/20/15, untimed, described a "tiny scratch like remainder" of left buttock wound. Review of the "week 3" assessment dated 7/27/15, untimed, showed a "dime sized" open area to left buttocks. e. Review of the "Skin Integrity Impairment Care Plan" dated 7/15/15 showed the resident was at high risk [for skin breakdown], had impaired functional mobility, and was incontinent	F 314	1. Resident #32 has been reassessed for promotion of healing to the wound. Her plan of care has been updated. LN staff was in-serviced on prevention of skin breakdown and treatment of wound to promote healing on 8/10/15. Current residents received a head to toe skin check to assure no other residents had wounds. An audit of current residents treatment sheets was conducted to assure no other unidentified wounds were being treated. An audit will be conducted weekly by the DON or designee of the skin assessment sheets and the treatment books to assure there are no unidentified areas. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	WY0043	A. BUILDING _____ B. WING _____	C 07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 314	Continued From page 31 of "fecal." f. Review of the July 2015 TAR showed there were no new orders for treatment to the left buttock wound after identification of the wound on 7/27/15. g. Interview with the DON on 7/30/15 at 4:30 PM revealed she was not aware the resident had a wound. In addition, she stated the nurses should report wounds via the 24-hour report, and 4 days without proper treatment could have had a negative effect on the wound. h. Review of the "Skin Integrity" policy updated July 2014 showed "Procedure...7. Upon discovery of a newly identified skin impairment (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear surgical wound, etc.), the LN [Licensed Nurse] completes the following: Documents skin impairment that includes measurements of size, color, and presence of odor exudates, and presence of pain associated with the skin impairment in the nurse's notes and on Weekly Wound Evaluation. Notifies the Physician and obtains a Treatment order if needed, document on the Treatment Administration record (TAR) after implemented...Implements interventions and document on the resident's care plan and Care Directive..."	F 314		8/18/15
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	**F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** It is the intent of this facility to ensure that the environment remains free of accidents and hazards.	

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F 323	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the environment remained free of accident hazards for 1 of 1 wall-hung water features in the secure unit. The findings were: 1. Observation on 7/27/15 at 3:25 PM showed a water feature decoration was hung on the wall in the secure unit next to room 103. Further observation at that time showed a power cord was hanging down from this fixture, with the plug at the level of the handrail. 2. Observation on 7/29/15 at 12:05 PM showed the power cord from the water feature continued to hang down from the fixture, with the plug at the level of the handrail. 3. Interview with CNA #3 on 7/30/15 at 3:07 PM revealed the staff member had to redirect a resident from pulling on the cord of the wall hanging. 4. Interview with the maintenance director on 7/30/15 at 3:15 PM revealed the water feature could be pulled off the wall and if it landed on someone it could injure them.	F 323	1. The water feature next to room 103 was removed on 7/30/15. An in-service for facility staff was conducted on 8/10/15 on reporting hazards to maintenance. 2. The water feature next to room 103 was removed on 7/30/15. An in-service for facility staff was conducted on 8/10/15 on reporting hazards to maintenance. 3. The water feature next to room 103 was removed on 7/30/15. An in-service for facility staff was conducted on 8/10/15 on reporting hazards to maintenance. Facility grand rounds were conducted to ensure that the facility is free of potential hazards. The ED or designee will conduct weekly rounds to identify hazards and follow procedure for removal. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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F 329	Continued From page 33 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to adequately monitor for adverse effects of medications for 1 of 10 sample residents (#14). The findings were: Review of the 7/8/15 admission MDS assessment showed resident #14 had diagnoses that included lung, brain/spine, and liver cancer. Review of the May, 2015 MAR showed the resident received promethazine HCL 25 mg three times daily. Review of the June, 2015 MAR showed the resident received promethazine HCL (an 25 mg by mouth three times daily from 6/1/15 until 6/7/15, and then received prochlorperazine maleate (an anti-emetic and anti-psychotic) 5 mg	F 329	**F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** It is the intent of this facility to adequately monitor for adverse effects of medications. Resident #14 has been reassessed via the AIMS testing and results reported to the physician. Resident #14 has been reassessed via the AIMS testing and results reported to the physician. LN staff was in-serviced on 8/10/15 on AIMS testing and those medications requiring it. An audit of current facility residents receiving medications that are known to cause tardive dyskinesia has been completed to assure they have been assessed using the AIMSs tool. Positive signs have been reported to the physician. The DON or designee will audit residents receiving medications	8/18/15

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F 329	Continued From page 34 by mouth three times daily from 6/8/15 through 6/30/15. Review of the July, 2015 MAR showed the resident continued to receive the prochlorperazine maleate 5 mg by mouth three times daily. The following concerns were identified: a. Observation of the resident on 7/28/15 at 10 AM showed the resident had a protruding tongue. Review of the resident's medical record failed to show an AIMS (abnormal involuntary movement scale) assessment had been completed. b. According to the State Operations Manual, residents taking medications such as promethazine HCL and prochlorperazine maleate must be adequately monitored for tardive dyskinesia (a disorder characterized by abnormal, recurrent, involuntary movements that may be irreversible and typically present as lateral movements of the tongue or jaw, tongue thrusting, chewing, frequent blinking, brow arching, grimacing, and lip smacking, although the truck or other parts of the body may also be affected). c. Interview with the DON on 7/29/15 at 2:45 PM revealed an AIMS assessment had not been previously completed on the resident for the use of prochlorperazine maleate, and that an assessment had been completed that day. Review of the newly completed AIMS assessment showed the resident's tongue protrusion was not recorded in the assessment. Further interview with the DON at that time revealed she had not recorded the resident's tongue protrusion on the assessment because it was "not a new symptom."	F 329	requiring AIMS weekly to assure current AIMS assessments have been done. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 35 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, family interview, and staff interview, the facility failed to provided routine and emergency medications to 1 of 10 sample residents (#35). The findings were: 1. Review of the face sheet showed resident #35 had diagnoses that included dementia with behavior disturbance, diabetes mellitus, hypertension, generalized pain, and constipation. The following concerns were identified: a. Interview with a family member on 7/30/15 at 9:20 AM revealed the resident began to have increased behaviors at the end of May, 2015 when the facility moved the resident to a different	F 425	F 425 483.60(a),(b) PHARMACEUTICAL SVCACCURATE PROCEDURES, RPH It is the intent of this facility to provide routine and emergency medications to residents. 1. Resident #35 no longer resides within the facility. In-service with facility LN staff was conducted 8/10/15 regarding safe keeping of residents medications that leave the facility for a temporary period with an anticipated return. An audit of current facility residents medications regimens along with their supply of medications was audited to assure ordered medications were available. The DON or designee will audit the med supply weekly to assure discharged meds	8/18/15

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F 425	Continued From page 36 room. According to the family member, the resident was transferred to a behavioral center in another state to be treated, with the expectation the resident would return to the facility. The resident returned to the facility on 7/17/15, but was at the facility only for a short time due to his/her behaviors. The family member stated the resident did not receive any medications for his/her agitation when s/he returned to the facility on 7/17/15 because the facility had thrown the resident's medications away after s/he was transferred on 7/7/15. b. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors. c. Review of the Resident Transfer Form dated 7/7/15 showed the resident was being transferred for treatment for "intrusive wandering behaviors." The form indicated the resident's bed was being held. d. Review of the incident report dated 7/17/15 showed the resident returned to the facility on 7/17/15 and was sent to another facility soon after on that day. However, review of the clinical record showed no nursing notes after 7/1/15, no admission orders, and no nursing assessment of the resident after his/her return. e. Interview with the administrator, DON, and regional director of clinical services on 7/30/15 beginning at 3:45 PM revealed the resident's medications were destroyed after his/her 7/7/15 transfer. The DON was unable to explain why the medications were destroyed, saying it was "not the usual procedure" for medications to be destroyed when a resident was temporarily transferred. The DON stated she was working on another hall on 7/17/15, and did not know if the transferring facility had given report on the	F 425	are not destroyed for residents who are expected to return to the facility. Trends identified will be reported to the QAPI committee weekly and as needed until lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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F 425	Continued From page 37 resident before he was returned to the facility. Further, the DON stated the facility had difficulty getting "hard scripts [prescriptions]" from the transferring facility.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	**F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** It is the intent of this facility to ensure infection prevention practices are followed. 1. Resident #32 has been reassessed for safe transfer status while assuring proper positioning of catheter. An in-service for nursing staff was conducted on 8/10/15 regarding appropriate placement of catheter bags during resident transfer. An audit of current facility residents with catheters has been conducted to assure proper placement to prevent infection. The DON or designee will conduct weekly rounds on residents with catheters to assure proper placement. Trends identified will be reported to the QAPI meeting monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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F 441	Continued From page 38 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and nursing procedure review the facility failed to ensure infection prevention practices were followed by staff for 1 of 1 sample residents (#32) with a urinary catheter. The findings were: 1. Review of the 7/9/15 admission MDS assessment showed resident #32 had diagnoses that included cerebrovascular accident, muscle disorder, and generalized pain. Further review showed the resident required the total assistance of 2 or more persons for transferring and the extensive assistance of 1 person for bed mobility, dressing, and personal hygiene. Further review showed the resident had a Foley catheter and a history of urinary tract infection. The following concerns were identified: a. Observation of a transfer on 7/28/15 at 9:38 AM showed CNA #3 and CNA #4 positioned the mechanical lift near the resident's bed and attached the straps of the sling that was under the resident to the mechanical lift. The resident's urinary drainage bag was secured to the lift bar of the mechanical lift. When the lift was raised, the urinary drainage bag was positioned above the resident's bladder. Continued observation at that time showed there was urine in the resident's catheter tubing. b. Interview with the DON on 7/30/15 at 10 AM revealed the urinary drainage bag should have been kept below the bladder to prevent	F 441		8/18/15

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F 441	Continued From page 39 backflow of urine into the bladder as it can cause an infection. c. According to the sixth edition of "Lippincott's Nursing Procedures" by Lippincott, Williams, and Wilkens, 2013, "Indwelling Urinary Catheter Care and Removal...Special considerations...To prevent reflux of urine, which may contain bacteria, avoid raising the drainage bag above the bladder."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain complete clinical records for 2 of 10 sample residents (#4, #35). The findings were: 1. Review of the face sheet for resident #35 revealed s/he was admitted to the facility on 10/7/2013, when the facility was owned by a different corporation. Further review revealed the	F 514	**F 514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** It is the intent of this facility to maintain complete clinical records on residents. 1. Resident #35 no longer resides within the facility. 2. Resident #4 clinical record has been audited to assure record is complete since 7/17/15 re-admission. An in-service for LN and department manager staff was conducted on the requirements for complete medical records.	8/18/15

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F 514	Continued From page 40 resident had diagnoses that included dementia with behavior disturbance, diabetes mellitus, hypertension, generalized pain, and constipation. The following concerns were identified: a. Review of the resident's medical record revealed a physician order dated 7/7/15 to transfer the resident to a different facility as a temporary placement for behaviors. b. Further review of the medical record showed no nursing notes were made after 7/1/15. There was no documentation of the resident's transfer or the need for transfer. c. Review of the incident report dated 7/17/15 showed the resident returned to the facility on 7/17/15 and was sent to another facility soon after. However, review of the clinical record showed no documentation on the resident after 7/1/15, no documentation indicating the resident returned to the facility on 7/17/15, and no documentation to indicate the need for the resident to be transferred again on 7/17/15 to another facility. 2. Review of the face sheet showed resident #4 was originally admitted to the facility on 5/19/15 with diagnoses including Alzheimer's disease, dementia with behaviors, generalized pain, anxiety, and depression. Review of the 7/7/15 nurse's note showed the resident was temporarily discharged to a behavioral health facility on 7/7/15. Review of the Nursing Admission Evaluation showed the resident was readmitted to the facility on 7/17/15. The following concerns were identified: a. Review of a discharge notice dated 6/13/15 showed the notice was provided to the resident's POA, with a planned discharge date of 7/14/15. The notice indicated the resident was to be discharged to a residential address, due to non-payment.	F 514	3. An in-service for LN and department manager staff was conducted on the requirements for complete medical records. An audit of current facility residents clinical records has been completed to ensure no missing items. The medical records director or designee will audit newly admitted residents records and discharged records weekly all other residents records quarterly. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate. Compliance shall be complete by August 18, 2015.	8/18/15

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F 514	Continued From page 41 b. Review of the resident progress note (untimed), dated 7/7/15 showed the resident was discharged to a behavioral health facility on that date due to increased behaviors. There was no documentation in the notes to indicate the original discharge plan had been changed or why. Further review showed no documentation of increased behaviors until 7/7/15, the date of discharge. 3. Interview with the administrator, DON and regional director of clinical services on 7/30/15 beginning at 3:45 PM revealed the opportunity to send the residents to the behavioral health facility "fell into [their] lap" and confirmed the lack of documentation regarding the transfers.	F 514		8/18/15

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