STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535056	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 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 A complaint survey was conducted by Healthcare Licensing and Surveys from 12/14/16 through 12/15/16. Complaints reviewed in the course of this survey were complaint intake WY000002275, WY000002289, WY000002295, WY000002296, and WY000002325. The following common abbreviations are used throughout this document: DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**Initial Comment** Preparation and or execution of this plan of correction does not constitute the providers 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 167 SS=D	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Elliott — TITLE: Executive Director — (X6) DATE: 1/4/17

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.

RECEIVED
JAN 09 2017
Healthcare Licensing and Surveys

1/18/17 11:10am Spoke with Melissa Elliott - Administrator
POC accepted & agreed changes — Pimentel state surveyor

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F 167	Continued From page 1 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure survey results were posted in a location readily accessible to all residents. The census was 45. The findings were: Observation on 12/14/16 at 12:30 PM showed the survey results were in a binder labeled Wyoming Department of Health Survey Book located at the front nurse's station; however, the binder contained the survey results from July 2015. Observation on 12/15/16 at 10:51 AM showed another binder containing the state survey results from 2016 was placed behind the nurse's station underneath a shelf and not visible or accessible to residents or visitors. Interview with the administrator and DON on 12/15/16 at 10:51 AM confirmed the results from the most recent survey were not accessible to residents or visitors.	F 167	F167 **Corrective Action** the survey results binder from 2016 was placed above the nurse's station. **ID of Others** Ed/Designee will conduct walking rounds to ensure that survey binder is placed in an area accessible to residents and visitors. **Systemic Changes** ED/Designee will round daily to ensure that the survey binder is in an area accessible to residents. **Monitor** The results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Compliance Date: 1/5/17	1/5/17 PS
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 221		

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F 221	Continued From page 2 and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §482.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure restraints were assessed, monitored, and routinely released for 1 of 1 sample residents (#19) with a restraint. The findings were: 1. Review of the 12/1/16 quarterly MDS assessment showed resident #19 was moderately cognitively impaired with a BIMS	F 221	F221 **Corrective Action** The wraps on resident #19 were immediately removed. **ID of Others** DON/Designee conducted a facility wide audit to ensure no other residents had any restraints. **Systemic Changes** DON/Designee will conduct weekly audits to ensure that no residents have restraints due the wrapping of an appendage education has been provided to the LPN/RN staff members. **Monitor** The results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Compliance Date: 1/5/17	1/5/17 PS

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F 221	Continued From page 3 (brief interview for mental status) score of 9 and was not totally dependant for eating. The following concerns were identified: a. Observation on 12/14/16 at 4:53 PM showed the resident had a dressing wrap applied to both of his/her hands and arms. The resident's fingers and thumbs were completely covered in such a way as to prevent the resident from grabbing or holding items. b. Review of the medical record showed the wraps had not been assessed as a restraint to ensure the least restrictive alternative was in use. Further, there was no evidence the wraps were removed regularly to allow the resident access to his/her hands, and no evidence of ongoing re-evaluation of the restraint. c. Interview with the DON on 12/15/16 at 10:30 AM confirmed the wraps prevented the resident from using his/her hands. Further, she revealed the facility removed the wraps daily only to change the dressing and they had not assessed the wraps as a restraint.	F 221		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure residents were free of significant medication errors for 1 of 3 sample residents (#17) with transdermal pain medication orders. The findings were: 1. Review of the 11/10/16 quarterly MDS assessment showed resident #17 had diagnoses that included rheumatoid arthritis and unspecified	F 333		

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F 333	Continued From page 4 pain. Review of the September 2016 medication administration record (MAR) showed Fentanyl (narcotic pain medication) 12 mcg/hr (micrograms per hour) transdermal (application of medication through skin absorption) patch was to be applied every 72 hours. The following concerns were identified: a. Review of the September 2016 MAR showed the patch was signed off as being administered on 9/5/16 and again on 9/6/16. There was no documentation to show both patches were not in use at the same time or to show why the second patch was applied prior to the 72 hour date. b. Review of the September 2016 MAR showed a patch was applied on 9/10/16, 96 hours after the 9/6/16 application. c. Review of the September 2016 MAR showed a patch was applied on 9/14/16, 96 hours after the 9/10/16 application. d. Review of the September MAR and nurse's notes between 9/5/16 and 9/17/16 showed no evidence the resident was placed on monitoring for a medication error related to the Fentanyl administration. e. Interview with the DON on 12/15/16 at 10:30 AM confirmed administration of the Fentanyl patch more than 72 hours after the previous patch was a medication error, the resident should have been monitored for side effects at that time, and the physician and family should have been notified. Further, she revealed staff should have documented the reason patches were administered on both 9/5/16 and 9/6/16.	F 333	F333 **Corrective Action** Resident #17s fentanyl patch was checked immediately for placement and timely administration. Physician was notified of medication error as well as acute observation initiated for negative outcomes which none observed for resident #17. **ID of** Others Facility wide audit conducted to ensure no other residents receiving a fentanyl patch went more than 72 hours without it being changed. **Systemic Changes** Education provided to LN staff regarding documentation as a med error when a fentanyl patch has gone longer then the required time to be changed. DON/Designee will conduct weekly audits to ensure that no other residents went longer then the prescribed time before changing their fentanyl patch. **Monitor** The results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Compliance Date: 1/5/17	1/5/17 FS