PRINTED: 06/26/2017
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	R-C 06/19/2017

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 post-survey revisit to the 4/28/17 complaint survey was conducted by Healthcare Licensing and Surveys on 6/19/17.	{F 000}	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
{F 309} SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.	{F 309}	F309 Corrective action: Residents identified as number 4 and 5 had physician contacted for Blood sugars that were out of parameters ID of others: DNS DNS/Designee to review all other residents receiving insulin to validate that the physician was contacted for all May 2017 and June 2017 blood glucose levels that were out of parameters. Any identified residents with missing blood glucose levels or levels outside of parameters will have physician notification. Systemic Changes: DNS/Designee has provided education Licensed nurses regarding physician notification of blood glucose levels outside of parameters, Less than 80 and greater than 350 mg/dl.	7/7/2017
	483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Manley RN | TITLE | (X6) DATE: 7/6/2017

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.

JUL 06 2017
Healthcare Licensing and Surveys

POC accepted with a DOC of 7/7/17 I spoke with the DON, Rebecca Manley at 10:38 AM on 7/7/17. Jean Flynn S

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{F 309}	Continued From page 1 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to follow physician's orders related to appropriate management of blood sugar levels for 2 of 5 sample residents (#4, #5) with diabetes. The findings were: 1. Review of the medical record showed resident #4 had a diagnosis of type 2 diabetes mellitus. According to the "Diabetic Orders" dated 4/18/17 the physician was to be notified of blood sugars above 400 milligrams per deciliter (mg/dl) or below 80 mg/dl. The following concerns were identified: a. Review of the May 2017 medication administration record (MAR) showed the resident had blood sugar levels below 80 mg/dl on the following dates: 5/1, 5/2, 5/10, 5/11, 5/13, 5/16, 5/16, 5/20, 5/21, 5/25, 5/27, and 5/28. b. Review of the June 2017 MAR revealed the resident had blood sugar levels below 80 mg/dl on 6/3, 6/4, and 6/10. c. Review of the medical record and review of faxes provided by the facility revealed the physician was notified of the low blood sugars on 5/1, 5/2, 5/11, 5/13, 5/16, 5/21, and 5/25 (7 of the 15 dates with low blood sugars). There was no evidence the physician was notified on the other dates. d. On 6/19/17 at 3:12 PM the staff development coordinator (SDC) stated she was unable to find any further documentation related to physician notification. 2. Review of the medical record showed resident	{F 309}	Monitoring: DNS/Designee to conduct daily audit of residents receiving insulin to ensure physician notification on all blood glucose levels outside of parameters. Results of audits to be taken to QAPI to determine continued frequency of audits .	

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7/1/17 JH

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{F 309}	Continued From page 2 #5 had a diagnosis of type 2 diabetes mellitus. According to the "Diabetic Orders" dated 5/3/17 the physician was to be notified of blood sugar levels below 80 mg/dl or above 350 mg/dl. The following concerns were identified: a. Review of the MARs from 5/21/17 through 6/19/17 showed the resident had blood sugar levels above 350 mg/dl on the following dates: 5/24, 5/25, 5/26, 5/27, 5/29, 5/30, 6/2, 6/3, 6/5, 6/7, 6/8, 6/11, and 6/15. In addition, the resident had blood sugar levels below 80 mg/dl on 6/2, 6/3, 6/9, 6/10 and 6/18. Review of the medical record and review of faxes provided by the facility showed no evidence the physician was notified of the blood sugar levels on those dates. b. On 6/19/17 at 3:12 PM the SDC stated she was unable to find any further documentation related to physician notification.	{F 309}		