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 _____	09/27/2018

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 recertification survey was conducted by Healthcare Licensing and Surveys from 9/24/18 to 9/27/18. Also reviewed in the course of the survey was complaint intake WY00002628. The following common abbreviations are used throughout this document: DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		10/22/18

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

Electronically Signed | 10/19/2018

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F 623	Continued From page 1 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual	F 623		

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 4 of 5 sample residents (#4, #30, #49, #154) who transferred to the hospital.	F 623	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the providers admission of or agreement with	

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F 623	Continued From page 3 The findings were: 1. Review of nurse's notes showed resident #4 was transferred to the hospital via ambulance on 9/18/18. Further, review of the medical record showed no evidence a written transfer notice was given to the resident or the resident's representative. 2. Review of nurse's notes showed resident #30 was transferred to the hospital on 8/16/18. Further, review of the medical record showed no evidence a written transfer notice was given to the resident or the resident's representative. 3. Review of nurse's notes dated 7/12/18 showed resident #49 was transported to the emergency department by ambulance. Further, review of the medical record showed no evidence a written transfer notice was given to the resident or the resident's representative. 4. Review of nurses notes showed resident #154 was transferred to the hospital on 6/23/18. Further, review of the medical record showed no evidence a written transfer notice was given to the resident or the resident's representative. 5. Interview with the administrator on 09/26/18 11:48 AM verified the facility did not give a notice of the transfer to the residents or the residents' representatives.	F 623	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. F623 Corrective Action: Transfer form will be implemented to center transfer procedure. Ombudsman will be notified monthly of center transfers. All transfers since survey exit, had the transfer form provided and transfer list has been sent to the ombudsman. Residents identified during the survey as #4, #30, #49, #154 who transferred to the hospital are unable to have transfer form provided. ID of others: All residents who have a need to be transferred out of the facility are identified to be at risk Systemic changes: All Licensed Nurses (LN) have been educated by DNS/designee on transfer form and policy as of 9/26/18. Transfer packets currently in use and located at both the front and back nurses stations have had a transfer form with specific verbiage included in 483.15(c)(5)including, but not limited to, the right to appeal and contact information for the Office of the State Long Term Care Ombudsman. The original transfer form will be maintained in the clinical chart and a copy will be given to the resident at time of discharge /transfer or as soon as practicable. The Director of Nursing Services (DNS)/designee will ensure Ombudsman is sent transfer lists monthly. Monitoring: All residents transferred from the center will have transfer paperwork	

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F 623	Continued From page 4	F 623	reviewed to ensure compliance with policy weekly X 4 weeks then monthly X 2 months by DNS/designee. Director of Nursing Services (DNS)/designee will ensure Ombudsman is sent transfer lists monthly. Results from review and transfer lists will be taken to the facility monthly Quality Assurance/Performance Improvement (QAPI) x 3 months to determine compliance and frequency of ongoing monitoring. Date of Compliance: 10/22/18	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the MDS assessment was accurate for 4 of 19 sample residents (#30, #35, #39, #45). The findings were: 1. Review of the 8/6/18 significant change MDS assessment showed resident #30 used "other" restraints in the bed and chair daily. However, the following concerns were identified: a. Observations on 9/25/18 at 9:22 AM, 9:30 AM, and 10:47 AM revealed no restraints in use. 2. Review of the 9/3/18 quarterly MDS assessment revealed resident #35 used "other" restraints in bed and in the chair daily. The	F 641	Disclaimer Clause 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. Tag: 641 Corrective Action: Residents identified as #30 had data entered correctly, to reflect no restraint, on 9/24/18 MDS assessment. Residents # 35, 39 and 45 had a	10/22/18

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F 641	Continued From page 5 following concerns were identified: a. Observations on 09/25/18 at 9:29 AM and 10:48 AM showed no restraints in use. 3. Review of the 9/10/18 significant change MDS assessment showed resident #45 used "other" restraints in bed and in the chair daily. a. Observations on 9/25/18 at 9 AM and 11:59 AM showed no restraints in use. 4. During an interview on 9/25/18 at 2:15 PM the administrator stated they were coding the secure care unit (SCU) as a restraint on the MDS assessments. She confirmed the SCU should not have been coded as a restraint for these residents. 5. Resident #39 was admitted on 12/2/16 with diagnoses which included CVA and hypertension. Review of the annual MDS dated 9/4/18 showed the resident had restraints used when in chair or out of bed. The following concerns were identified: a. Observation on 09/24/18 5:22 PM showed the resident walked to the dining room using a walker, sat at the dining table. No restraints were visible. b. Review of the medical record showed no evidence of a physician's order for a restraint. c. Review of the care plan last revised on 6/15/18 showed the resident had a WanderGuard alarm. d. Interview on 9/26/18 at 5 PM with the MDS coordinator revealed she coded the WanderGuard as a restraint on the MDS. She confirmed the resident did not have restraints. 6. Review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,	F 641	modification to the most recent Minimum Data Set (MDS) completed by the MDS Coordinator on 10/1/18. ID of others: An audit of all current residents will be reviewed for accuracy against most recent MDS assessment section □P□ to ensure accuracy. Any residents who were coded in error will have a modification completed to the most recent MDS assessment by the MDS nurse. Systemic changes: All LN□s contributing to the MDS will be trained on Resident Assessment Index (RAI) section specific to coding the MDS assessment section □P□ restraints by Executive Director/designee. All MDS section P will be reviewed prior to transmission by the DNS/Designee. Monitoring: All MDS section P will be reviewed prior to transmission by the DNS/Designee and audited weekly x 4 weeks then monthly x 2 months. Results of these audits will be taken to facility monthly QAPI monthly x 3 months to determine compliance and frequency of ongoing monitoring. Date of Compliance: 10/22/18	

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F 641	Continued From page 6 Version 1.16, October 2018, showed for P0100: Physical Restraints, "...When coding this section, do not consider as a restraint a locked/secured unit or building in the which the resident has the freedom to move about the locked/secured unit or building." In addition, for P0200: Alarms "...Wander/elopement alarm includes devices such as bracelets, pin/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert staff when the resident nears or exits a specific area or the building."	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability	F 645		10/22/18

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F 645	Continued From page 7 authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an	F 645		

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F 645	Continued From page 8 intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the preadmission screening and resident review (PASARR) was completed prior to admission for 1 of 8 sample residents (#34) reviewed. The findings were: 1. Review of the medical record showed resident #34 was admitted to the facility on 6/2/18. Review of the PASARR level I submitted 6/2/18 showed a level II was required. However, review of the level II determination showed it was not completed until 7/3/18 (31 days after admission). During an interview on 9/27/18 at 9:14 AM the business office manager and the administrator stated the person who filled out the PASARR level I filled it out incorrectly, and should have indicated it was a categorical determination because it was expected the resident would require less than 120 days of nursing facility services. They further stated that once the resident was admitted, it was clear that the resident was going to require long-term placement and they then requested the level II PASARR.	F 645	Disclaimer Clause 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. Tag: 645 Corrective action: Resident identified as # 34 had a PASARR level 2 completed on 7/3/2018. ID of others: An audit will be conduction on all current residents to determine if any other resident was in need of having a PASARR level 2 completed. Any identified residents will have PASARR level 2 submission form completed. Systemic changes: Admissions Coordinator, Business Office Manager (BOM), Health Information Manager, Executive Director and the DNS will complete education on PASARR level 2 requirements. Education provided by Executive Director by 10/20/18. All new referrals will be reviewed for criteria that would trigger a PASARR level 2 prior to admission by the BOM and/or Admission Coordinator .Monitoring: All new referrals will be reviewed/audited for criteria that would trigger a PASARR level 2 to be	

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F 645	Continued From page 9	F 645	completed prior to admission by the BOM and/or Admission Coordinator weekly X 4 weeks then monthly X2 months. Admissions audits will be reviewed at the facility monthly QAPI x 3 months to ensure assessment is being completed prior to center admission when applicable and to determine the need for ongoing monitoring. Date of Compliance: 10/22/18	