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 07/03/2019

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 7/1/19 to 7/3/19. The survey was prompted by complaint intake WY000002865.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to effectively manage pain in 1 of 7 residents (#4) reviewed for pain management. The findings were: 1. Medical record review showed resident #4 was admitted to the facility on 5/7/18 and had diagnoses which included end stage renal disease with renal dialysis, hemiplegia, and neoplasm of the retroperitoneum. Review of nursing progress notes showed the resident went to the emergency room on 4/12/19, and was subsequently diagnosed with terminal cancer and placed on comfort care. Review of the significant change minimum data set (MDS) assessment with an assessment reference date of 4/24/19 showed the resident had a brief interview for mental status (BIMS) score of 14 out of 15, indicating the resident was cognitively intact. Additionally, the resident reported the presence of pain that was almost constant, interfered with sleep and caused him/her to limit day-to-day	F 697	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. Corrective action: Resident identified as #4 has expired. A late medication error incident report was completed and physician was notification. Documentation reviewed during time of the medication discrepancy for this patient yielded no documented increased pain above her baseline between 4/18/19 and 4/20/19. ID of others: All residents who report pain or are currently ordered medication for pain are	7/31/19

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

Electronically Signed | 07/25/2019

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 07/03/2019

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 697	Continued From page 1 activities. The resident rated the pain level at 7 out of 10. The resident died on 4/29/19. The following concerns were identified: a. Review of the medication administration record (MAR) for April 2019 showed an order, initiated on 2/28/19, for oxycodone (opiod pain medication) 7.5 mg by mouth every 4 hours as needed for pain. b. Further review of the physician orders showed an order written by the physician and dated 4/18/19 to "increase oxycodone 7.5 mg by mouth every 2 hours PRN [as needed]." c. Review of the MAR for 4/18/19, and 4/19/19 failed to show the order for oxycodone 7.5 mg by mouth every 2 hours PRN. d. Review of the nursing progress note dated 4/19/19 and timed 3:28 PM showed "resident C/O [complains of] pain generalize administered PRN pain medication with good results, don't hold resident till next available dose will contact physician." Further review of the medical record showed no evidence the physician was contacted on 4/19/19 regarding the resident's pain. e. Review of the nursing progress note dated 4/20/19 and timed 4:25 AM showed "Resident has pain continually, [his/her] current medications have not been effective in controlling her pain. S/he has requested her oxycodone every 3 hours, she can have a dose every 4 hours." f. Further review of the nursing progress note dated 4/20/19 and timed 7:35 PM showed "...the doctor was called at 1730 [5:30 PM] he ordered...the oxycodone 7.5 mg to be increased to every two hours...". g. Additional review of the physician orders showed a telephone order dated 4/20/19 to increase oxycodone 7.5 mg by mouth to every 2 hours PRN. h. Interview on 7/3/19 at 12:10 PM with the	F 697	at risk. Systemic changes: Licensed nursing staff have been educated on the correct way to enter medication orders on to the MAR, documentation of medication and medication administration policy and pain management policy and procedure. All new orders for pain medication will be verified on the MAR for correct initiation date. All current residents will have a pain evaluation completed. Any resident reporting they are not satisfied with their current pain control, or nonverbal residents or those who have the advanced dementia pain scale utilized with 4 or higher pain score, will have reviews forwarded to their respective physicians for consideration of new or modified treatment order. Monitoring: DNS/HIM/designee will audit MAR for correct initiation dates on all pain medication orders 3x week for 4 weeks then no less than weekly x 2 months. Results will be taken to QAPI to determine ongoing frequency and monitoring. DNS/designee will monitor pain monitor flow sheets for completion and indications of adequate pain control 3x week for 4 weeks then no less than weekly x 2 months. Results will be taken to QAPI to determine ongoing frequency and monitoring.	

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 07/03/2019

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 697	Continued From page 2 administrator revealed she was not sure why the 4/18/19 written order from the physician was missed. She stated the physician filled out the orders in the office and placed them in an envelope designated for the facility. She stated every Monday, Wednesday, and Friday someone from the facility went to the physician offices and picked up the envelopes with orders. Once the orders arrived at the facility they were processed. She also stated normally the physician would call with an order that was high priority.	F 697		