

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

PRINTED: 10/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/24/2019
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	INITIAL COMMENTS A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on September 24, 2019. Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association. The facility was a fully sprinklered, single story building with a basement of Type V (111) construction built in 1956. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 82 certified Medicare and Medicaid beds with a census of 56 residents.	K 000			
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of	K 321			10/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/18/2019

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.

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K 321	Continued From page 1 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain hazardous area enclosures as required could result in injury or death during an emergency. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 09/24/2019 at 2:00 PM in the basement boiler room revealed the self closing corridor door failed to close when tested. Interview with the facility maintenance director at the time of observation acknowledged the door failed to close, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section: 19.3.2	K 321	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. Corrective action: the door to the boiler room in the basement had closing mechanism replaced to ensure door would self-close on 9/25/19. ID of others: Maintenance Director completed an audit of self-closing doors to ensure doors close. Systemic changes: Maintenance Director will add self-closing doors to the monthly inspection log. Monitoring : Maintenance		

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K 321	Continued From page 2	K 321	Director/designee will audit self-latching doors 1x Q week for 4 weeks then no less than 2x per month for two months. Results of audit will be taken to QAPI to determine ongoing frequency of monitoring.	10/30/19	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain portable fire extinguishers in accordance with the 2012 NFPA 101, Life Safety Code and the 2010 NFPA 10, Standard for Portable Fire Extinguishers. Failure to maintain portable fire extinguishers as required could result in injury or death during an emergency. The deficiency affected one (1) of four (4) smoke compartments. The findings were: Observation on 9/24/2019 at 2:45 PM at the frontier nursing station revealed a portable fire extinguisher obstructed by a trash can and a portable vital signs station. Interview with the facility maintenance director at the time of observation acknowledged the deficiency, and indicated awareness of the requirement. Interview with the facility administrator at the time	K 355	Corrective action: the fire extinguisher located in the frontier nurses station was moved across from the nurse's station to TV area to ensure ease of access on 9/25/19. ID of others: Maintenance Director will audit other fire extinguishers in the center to ensure that they are readily accessible. Systemic changes: Maintenance Director will add fire extinguisher accessibility to monthly fire extinguisher inspection logs Monitoring: Maintenance Director/designee will audit fire extinguishers 1x Q week for 4 weeks then no less than 2x per month for two months. Results of audit will be taken to QAPI to determine ongoing frequency of monitoring.		

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K 355	Continued From page 3 of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.2.5.12; 9.7.4.1 2010 NFPA 10, Section: 7.2.2(2)	K 355			
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems in accordance with the 2012 NFPA 101, Life Safety	K 920			10/30/19
			Corrective action: the extension cord from the therapy gym was removed 9/24/19		

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K 920	Continued From page 4 Code and the 2011 NFPA 70, National Electrical Code. Failure to maintain electrical systems as required could cause a fire resulting in injury or death. The deficiency affected one (1) of numerous rooms in the facility. The findings were: Observation on 09/24/2019 at 3:19 PM in the physical therapy room revealed an extension cord. Further observation revealed several electrical items plugged into the extension cord. Interview with the facility maintenance director at the time of observation acknowledged the extension cord, and indicated awareness of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections: 19.5.1.1; 9.1.2 2011 NFPA 70, Section: 400-8	K 920	Id of others: Maintenance Director will audit resident care areas to ensure there are not extension cords in use. Systemic Changes: Department heads will be educated on regulation as it relates to use of extension cords in resident care areas. Monitoring: Maintenance Director/designee will audit resident care areas 1x Q week for 4 weeks then no less than 2x per month for two months. Results of audit will be taken to QAPI to determine ongoing frequency of monitoring.		

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E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on September 24, 2019. Based upon the findings of the survey team, it was determined the facility was in compliance with all requirements.	E 000			

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