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 _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 9/23/19 to 9/26/19. The following common abbreviations are used throughout this document: ARD- Assessment Reference Date cm- centimeters CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		10/30/19

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

Electronically Signed | 10/19/2019

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F 657	Continued From page 1 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan was revised and individualized for 1 of 17 sample residents (#1). The findings were: Review of the annual MDS assessment with an ARD of 6/26/19 showed resident #1 was at risk for pressure ulcers, but did not have any pressure ulcers. Review of the quarterly MDS assessment with an ARD of 9/24/19 showed the resident had 2 stage 2 pressure ulcers during that look-back period. Review of the 9/12/19 un-timed physician order showed "Please evaluate for a pressure relieving device for the back of [resident's] wheelchair." Review of the 9/9/19 weekly skin evaluation showed the resident had a stage 2 pressure ulcer on the spine area and the oxygen tank on the wheelchair was a contributing factor. Review of the 9/23/19 un-timed physician order showed staff were ordered to apply skin prep to the top of the right ear twice daily and as needed and to offload right ear from O2 tubing with foam protectors. Review of the 9/20/19 timed at 7:17 PM nurse's note showed the resident had an area that was bleeding on the top of the right ear, and the nurse educated all staff of the need for the	F 657	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. F 657- Care Plan Timing and Revision Corrective action: Resident #1 had care plan and care direct forms updated to include care interventions for wheelchair and oxygen tank positioning and foam ear protectors to oxygen tubing on 9/26/19. ID of others: An audit was conducted on all residents with pressure ulcers to discern if the care plan and care direct forms included interventions on 10/2/19. Any care plans or care direct forms not updated were corrected. Interventions beyond what can be denoted on the care direct forms will be added to the individual	

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F 657	Continued From page 2 oxygen tubing to be secured off the resident's ear. The following concerns were identified: a. Review of the care plan showed the resident had a stage 2 pressure ulcer to the spinous process. This was initiated and last revised on 9/10/19 and failed to include specific interventions related to the wheelchair and oxygen tank positioning. b. Review of the care plan showed on 9/20/19 the skin impairment to the right ear was added. The interventions failed to include the foam protectors to the tubing or any special instruction to secure the tubing behind the resident's head not over the ears. c. Review of the "Care Directive Form" showed it was last updated on 7/9/19 and did not include any interventions related to the back wound, oxygen tank, positioning in the wheelchair, or the need for securing the oxygen tubing off the ears and using foam protectors. d. Interview with the DON on 9/26/19 at 10:47 AM revealed the CNAs used the care directive form that was kept in the resident's room to provide care. She also confirmed there were no care interventions included on the care plan or the care directive form related to the wound from the wheelchair and O2 canister, or the need to apply foam to the oxygen tubing.	F 657	service plans for staff reference. Systemic changes: Licensed Nursing (LN) staff will be educated on updating care plans and care direct forms with addition of interventions. Information beyond what can be denoted on the care direct forms will be added to the individual service plans for staff reference. Monitoring: DNS/designee will audit care plans and care direct forms for residents with pressure ulcers 1x week for 8 weeks then 2x month. Results will be taken to QAPI to determine need of ongoing frequency of audits and monitoring.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		10/30/19

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F 686	Continued From page 3 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, family interview and staff interview, the facility failed to ensure interventions to prevent and heal pressure ulcers were followed for 1 of 4 sample residents (#1) with pressure ulcers. The findings were: 1. Review of the annual MDS assessment with an ARD of 6/26/19 showed resident #1 was at risk for developing pressure ulcers, but none were present at the time of the assessment. Review of the quarterly MDS assessment with an ARD of 9/24/19 showed the resident had developed two stage 2 pressure ulcers during that look-back period. Interview with the resident's spouse on 9/23/19 at 5:09 PM revealed the resident had developed a wound on his/her back related to the oxygen tank on the back of the resident's wheelchair. S/he stated the nursing staff were providing wound care and there had been no changes s/he was aware of related to the wheelchair. Review of the 9/9/19 weekly skin evaluation showed the resident had a "stage II pressure ulcer" to the thoracic spinal area measuring 0.6 cm by 0.6 cm. The note showed it was "from oxygen tank on w/c [wheelchair]." The physician was notified and review of the 9/9/19 untimed physician order showed skin prep and border gauze to "stage I pressure ulcer." Review of the 9/12/19 untimed physician order showed	F 686	F 686- Treatment/Svcs to prevent/heal pressure ulcer Corrective action: Resident #1 had pressure relieving measure added to back of wheelchair and wheelchair evaluation completed on 10/1/19 by the therapy department, recommendations were implemented as preventative measures, foam ear protectors were added to the care plan and care direct form 9/26/19 ID of others: An audit was conducted to determine all residents with pressure ulcers, or at risk for pressure ulcers. Residents identified will have care plan and care direct forms updated. Information beyond what can be denoted on the care direct forms will be added to the individual service plans for staff reference. Systemic changes: LN staff will be educated on regulation regarding treatment and preventative measures and timely initiation of treatment/implementation of preventative measures related to pressure ulcers. DNS/designee will complete an audit of residents with pressure ulcers and at risk	

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F 686	Continued From page 4 "Please evaluate for a pressure relieving device for the back of [resident's] wheelchair." Review of the 9/18/19 skin evaluation showed "PU [pressure ulcer] has decreased in size. No s/sx [signs/symptoms] infection. Staff continues to encourage res [resident] to lay down in between meals with not much success. Will continue to encourage. Also, therapy is looking at alternatives for res' [resident's] w/c [wheelchair] back to assist in reducing pressure d/t [due to] res [resident] will fall asleep in his w/c [wheelchair] leaning against the w/c [wheelchair] back. MD notified." The following concerns were identified: a. Observation on 9/23/19 at 6:03 PM showed the resident was seated in the wheelchair at the dining table. It appeared the back of the wheelchair was at a height of the resident's mid-back. It was noted when the resident leaned back in the chair the oxygen canister valve/nozzle was positioned where it contacted the resident's back. There was no additional cushioning placed between the resident and the chair back which was curved downward due to the tank hanging on the chair back. b. Observation on 9/24/19 at 1:41 PM showed the resident was seated in the wheelchair in his/her room. At that time the MDS nurse provided an amplifier to use to ask the resident questions. The resident indicated yes by a head nod that his/her back was "bothering" him/her. At that time, there was no additional cushion or padding between the resident and back of the wheelchair. c. Observation on 9/25/19 at 8:53 AM and at 10:37 AM showed the resident was seated in the wheelchair with nothing between the resident and the back of the wheelchair. d. Observation on 9/25/19 at 2:35 PM with RN #1 and RN #2 showed when the resident's	F 686	for pressure ulcers will have care plans and care direct forms reviewed and updated to ensure preventative measures are included on care plan and care direct cards. Information beyond what can be denoted on the care direct forms will be added to the individual service plans for staff reference. Monitoring: DNS/designee will audit care plans and care direct forms for residents at risk for pressure ulcers to ensure preventive measures are in place on care plan and care direct for or individual service plans and are implimented 1x week for 8 weeks then 2x month. Results will be taken to QAPI to determine need of ongoing frequency of audits and monitoring.	

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F 686	Continued From page 5	F 686		

shirt was lifted, there was an elongated, curved reddened area about an inch wide stretching from the bottom of one shoulder blade to the other shoulder blade. This reddened area had lightened by the time the observation had concluded.

e. Review of the 9/25/19 weekly skin evaluation timed at 1:13 PM showed the redness that was noted at the beginning of the evaluation from the resident leaning against the wheelchair back had started to subside as the resident leaned forward. The evaluation further showed "Pillow put in place between res [the resident] and w/c [wheelchair] back and res [the resident] likes this."

f. Review of the September 2019 treatment administration record showed "please evaluate for a pressure relieving device for back of wheelchair" dated 9/12/19. The need for this wheelchair evaluation was shown as an "FYI" with no documentation related to completion or progress.

g. Review of the care plan showed the resident had a stage 2 pressure ulcer to the spinous process. This was initiated and last revised on 9/10/19 and failed to include specific interventions related to the wheelchair and oxygen tank positioning.

h. Review of the "Care Directive Form" showed it was last updated on 7/9/19 and did not include any interventions related to the wound, oxygen tank, or positioning in the wheelchair.

i. Interview with the DON on 9/26/19 at 10:47 AM revealed there was no documented or formal evaluation done related to the wheelchair. She stated the position of the oxygen (O2) canister was changed and there was an order made for a new oxygen canister holder which would be applied to the resident's wheelchair once it was received. She further stated the CNAs used the

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F 686	Continued From page 6	F 686		

care directive form that was kept in the resident's room to provide care. She verified there were no care interventions related to preventing wounds from the wheelchair and O2 canister.

2. Review of the annual MDS assessment with ARD of 6/26/19 showed resident #1 was at risk, but did not have any pressure ulcers. Review of the 9/24/19 quarterly MDS assessment showed the resident had 2 stage 2 pressure ulcers during that look back period. Review of the 9/20/19 timed at 7:17 PM nurse's note showed the resident had a area that was bleeding on the top of the right ear. "Upon assessment the resident's O2 tubing was resting on ear, when it should be up secured to top backside of [his/her] head D/T [due to] resident has HX [history] of pressure sores similar to this in the past." The note went on to show the area was cleansed and skin prep was applied, the tubing was secured appropriately and all staff were educated related to the tubing placement and history. Review of the 9/23/19 at 12:21 PM nurse's note showed the resident had a stage 2 to the top of the right ear where the O2 tubing sits. The note included approximate measurements of "0.2 cm by 0.2 cm" and skin prep treatment applied and ear foam protectors applied to O2 tubing. The MD was notified at that time. Review of the 9/23/19 untimed physician order showed "Apply skin prep to the top of the right ear twice daily and as needed and to offload right ear from O2 tubing with foam protectors". Review of the 9/25/19 timed at 1:13 PM weekly skin evaluation showed the resident had a stage 2 pressure ulcer to the right ear, it was shown to have decreased in size with measurements of 0.2 cm by 0.2 cm. The plan was to continue to offload pressure on the ear from the O2 tubing with foam ear protectors.

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F 686	Continued From page 7 The following concerns were identified: a. Observation on 9/24/19 at 1:41 PM, 9/25/19 at 10:37 AM, 9/25/19 at 2:30 PM, and 9/25/19 at 3:26 PM showed there was no foam protection on the O2 tubing the resident was wearing over his/her ears. b. Interview with LPN #2 on 9/25/19 at 3:26 PM revealed the foam was expected to be on the oxygen tubing, and the resident sometimes took it off. The nurse went to the "supply closet" to find the foam. c. Review of the care plan showed on 9/20/19 the skin impairment to the right ear was added. The interventions failed to include the foam protectors to be applied to the tubing, or any special instruction to secure the tubing behind the resident's head and not over the ears. d. Review of the "Care Directive Form" showed it was last updated on 7/9/19 and did not include any interventions related to the ear wound or oxygen tubing.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		10/30/19

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F 761	Continued From page 8 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's recommendations, the facility failed to ensure expired medications were not available for resident use in 1 of 3 medication storage units (Frontier medication cart). The findings were: 1. Observation on 9/24/19 at 5:23 PM during the medication pass showed 2 Novolog 100 unit/milliliter multiple use vials with no written open date. Interview with LPN #1 at that time revealed the medication was for resident use and confirmed there was no written open date on the vials. 2. Interview with the DON on 9/25/19 at 11:28 AM revealed it was the expectation of the facility for staff to label the insulin with an expiration date when the insulin was placed into the medication cart. 3. Review of NovoLog safely storing diabetes medication found at https://www.rapidactinginsulin.com/novolog/using-novolog/storage-and-handling.html (retrieved 9/30/19) showed NovoLog stored at room	F 761	F 761- Label/storage drugs and biologicals Corrective action: undated Novolog vials were reviewed on 9/24/19 prior to survey exit. Vial verified to be opened on 9/24/19 was dated other vial was unable to have opened date verified and was discarded. ID of others: Any residents receiving insulin medication/biologics are at risk of having had medication administered that did not have open date on insulin label/bottle. Systemic change: DNS/designee will educate licensed nursing staff on the regulation regarding dating insulin/biologics upon opening. Monitoring: DNS/designee will audit medication cart for open dates on insulin/ biologics as appropriate. Audits will be conducted 3 week x 2 months then no less than 1x week x1 month. Results will be taken to QAPI to determine the need	

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F 761	Continued From page 9 temperature could be used up to 28 days.	F 761	for ongoing frequency and monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of product information, and staff interview, the facility failed to ensure food preparation equipment in the kitchen was in good condition, and that perishable drinks were marked with expiration dates in 3 of 4 refrigerators (Memory care, Frontier, Rehab). The findings were: 1. Observation on 9/25/19 at 11:30 AM showed the memory care unit refrigerator contained 3 cartons of health shakes. There were no dates marked on the cartons to show when they were thawed or when they expired. According to the	F 812	F 812 Food procurement, storage/prepare/serve-sanitary Corrective action: house supplement and Sysco shakes without open on dates were removed and discarded prior survey exit on 9/25/19. Kitchen equipment identified as having scratches or cracks were removed from the kitchen and replaced. ID of others: All residents are at risk from having been effected from deficient practice.	10/30/19

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F 812	Continued From page 10 instructions on the cartons, the health shakes expired 14 days from when thawed. Interview with CNA #1 at that time revealed she was unsure when the health shakes expired. 2. Observation on 9/25/19 at 11:43 AM showed in the Frontier station refrigerator there were 2 cartons of "Sysco Med Plus 2" a nutritional drink usually provided with medication passes. One of the cartons was marked with the date "9/22" the other was about 1/4 full and had no date marked to show when it was opened. According to the carton, the product expired 3 days after it was opened. 3. Observation on 9/25/19 at 12:16 PM showed the Rehab station refrigerator had 1 opened carton of "Sysco Med Plus 2" with no date marked. According to the carton, it expired 3 days after it was opened. Interview with LPN #2 at that time revealed she knew it was good for 3 days once opened, however did not know when it had been opened. She further stated the carton is usually gone quickly related to how many people receive it. 4. Observation on 9/25/19 at 11:53 AM in the kitchen showed the clean plastic measuring cups were hanging from a rack. The water had not been allowed to dry after washing and 2 were stored face up with water remaining inside the cups. In addition, 3 of the measuring cups had cracks and fissures in the plastic. Also stored on the rack was a large fry pan with very little non-stick coating remaining. There were visible scratches on the surface where the coating had been scraped away from use. 5. Interview with the Certified Dietary Manager	F 812	Systemic changes: CDM/kitchen staff and licensed nursing (LN) staff will be educated on the regulation requiring use by dates on supplements and. CDM will be educated on regulation regarding equipment condition issues. Monitoring: CDM/designee will audit resident refrigerators to ensure that use by dates are clearly printed on HS shake containers and supplements. Audits will be conducted 3 week x 2 months then no less than 1x week x1 month. CDM/designee will audit kitchen cookware weekly x 8 weeks then 2x month. CDM/designee will review results of audits at QAPI to determine need of ongoing frequency of audits and monitoring.	

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SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 812	Continued From page 11 (CDM) on 9/25/19 at 12:10 PM revealed the health drinks should not be stored in the refrigerators without dates to show expiration. The CDM also verified the measuring cups should be stored face down to dry, and equipment with condition issues needed to be replaced. 6. According to Food Code 2017, U.S. Public Health Service 4-101.11: "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be ...(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition."	F 812		