STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535056	A. BUILDING **01** B. WING _____	**09/22/2021**

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
E 000	Initial Comments An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on September 22, 2021. Based upon the findings of the survey team, it was determined that the facility was in compliance with all requirements. .	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on September 22, 2021. 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 40 residents. .	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless	K 222		11/15/21

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

Electronically Signed | 10/24/2021

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K 222	Continued From page 1 using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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K 222	Continued From page 2 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: . Based on observation and staff interview, the facility failed to maintain door in a means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain egress door as required could result in injury or death during an emergency. The deficiency affected one (1) of multiple exterior egress doors throughout the facility. The findings were: Observation on 09/22/2021 at 1:00 PM at the main entry doors to the facility revealed the doors were provided with a magnetic locking system. Further observation revealed that the locking system could only be released by staff via a wall-mounted keypad located at the interior of the entryway. It was observed that no delayed-egress or controlled-access systems were provided, and the doors could not be opened from the egress side without knowledge of the access code. Interview with the facility maintenance staff and administrator revealed that the locking system	K 222	1) Identified egress door provided with controlled-access button. Existing magnetic locks will be removed and replaced with double door CL151 locks along with a PIR motion detector. 2) Installation completed 11/15/21 3) Education regarding controlled access button provided to the staff. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months 5) AOC Date: 11/15/21	

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K 222	Continued From page 3 was being utilized to prevent unaccompanied entry of visitors due to COVID limitations, but was not intended to prevent egress by patients. It could not be established that locking of the egress doors was necessary for the clinical needs of patients, nor that special locking systems were required to accommodate special patient needs, in accordance with Sections 19.2.2.2.5.1 and 19.2.2.2.5.2. Interview with the facility maintenance staff and administrator at the time of observation acknowledged the deficiency, and indicated they were unaware of the egress requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101. Sections: 19.2.2.2.4; 19.2.2.2.5 .	K 222		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 511		9/22/21

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K 511	Continued From page 4 . Based on observation and staff interview, the facility failed to maintain adequate working space about electrical equipment to permit ready and safe operation and maintenance in accordance with the 2011 NFPA 70, National Electrical Code. Failure to maintain adequate working space could result in injury or death during maintenance or inspection. The deficiency affected two (2) of numerous locations of electrical equipment throughout the facility. The findings were: Observation on 09/22/2021 at 1:50 PM in the main level boiler room revealed two (2) 50 gal. drums stored immediately in front of the emergency power and normal power entry disconnects. Further observation revealed that a clear work space of 36 inches had been marked on the floor with yellow paint, but that the paint was severely faded. Observation on 09/22/2021 at 2:07 PM in the basement boiler room revealed miscellaneous items stored immediately in front of electrical panel "A". Further observation revealed that a clear work space of 36 inches had been marked on the floor with yellow paint, but that the paint was severely faded. Interview with facility maintenance staff at the time of each observation acknowledged each deficiency, and indicated that they were aware of the requirements. 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: 110.26	K 511	1) Identified areas were properly marked off and cleared as of 9/23/21. 2) Audit completed on 9/22/21 to identify any other areas showed two total areas one in main level boiler room and basement boiler room where 36 inches of clear work space not provided. 3) Maintenance director and maintenance assistant conduct daily checks and both areas identified in boiler rooms will be added and checked with their daily rounds. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months 5) AOC Date:9/22/21	

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