| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535056 | A. BUILDING **01**<br>B. WING _____ | **10/18/2022** |

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

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| E 000 | Initial Comments<br><br>An Emergency Preparedness survey was conducted by Healthcare Licensing and Surveys on 10/18/2022. The findings that follow demonstrate noncompliance with 42 CFR 483.73. | E 000 | | |
| E 015 SS=F | Subsistence Needs for Staff and Patients<br>CFR(s): 483.73(b)(1)<br><br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:<br>(i) Food, water, medical and pharmaceutical supplies<br>(ii) Alternate sources of energy to maintain the following:<br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(B) Emergency lighting.<br>(C) Fire detection, extinguishing, and alarm systems.<br>(D) Sewage and waste disposal. | E 015 | | 11/18/22 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 11/11/2022 |

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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| E 015 | Continued From page 1<br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br>(A) Food, water, medical, and pharmaceutical supplies.<br>(B) Alternate sources of energy to maintain the following:<br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br>(2) Emergency lighting.<br>(3) Fire detection, extinguishing, and alarm systems.<br>(C) Sewage and waste disposal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on document review and staff interview, the facility failed to demonstrate the ability to provided subsistence needs for staff and patients during an emergency. Failure to maintain these services could result in injury or death of staff, residents, and visitors during an emergency. The deficiencies affected the emergency preparedness of the facility. The findings were:<br><br>Review of the emergency preparedness plan on 10/18/2022 starting at 1:10 PM revealed that the facility had developed policies to provide food, water, and pharmaceutical supplies, as well as fuel for emergency power systems. However, the facility was not able to provide documentation to demonstrate that contracts were in place with | E 015 | 1) Identified areas of food, water, pharmaceutical supplies, and fuel for emergency power had policies in place in a case of an emergency and supplied written contracts for above areas.<br>2) Facility suppliers for above identified areas requested written contracts for services in case of an emergency.<br>3) Education given to ED and maintenance manger in regards to having written contracts with emergency services included in emergency preparedness.<br>4) Contracts will be reviewed via QAPI process and annually<br>5) AOC Date: 11/18/22 | |

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| E 015 | Continued From page 2<br>suppliers to ensure timely delivery of needed materials and supplies during an emergency event.<br><br>Interview with the facility maintenance manager at the time of the observation indicated that contracts may be available at the corporate office, but he could not confirm they were available.<br><br>Interview with the facility administrator at the time of exit again indicated that contracts may be available from the corporate office, but they were not available at the time of the survey.<br>Post-survey delivery by the facility administrator of a contract with the generator maintenance provider indicated contractual obligations for annual maintenance, but did not include language addressing the delivery of fuel during an extended emergency event. | E 015 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by Healthcare Licensing and Surveys on 10/18/2022.<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.90 (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.<br><br>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 39 | K 000 | | |

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| K 000 | Continued From page 3<br>residents. The findings that follow demonstrate noncompliance with CFR 483.90. | K 000 | | |
| K 222 SS=F | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>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 using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING | K 222 | | 11/18/22 |

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| K 222 | Continued From page 4<br>ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain delayed-egress systems in accordance with the 2012 NFPA 101, Life Safety code. Failure to maintain delayed-egress systems as required could result in injury or death in the event of an emergency. The deficiency affected all but one (1) of the exits to the exterior throughout the facility, and could impact all staff, residents, and visitors. The findings were:<br><br>Observation on 10/18/2022 at 2:10 PM of the exterior exit located adjacent to room 218 revealed that the door was provided with signage | K 222 | 1) Egress doors identified to have delayed egress when applying force all reprogramed to meet the irreversible process to release the lock per standard. Two doors identified to not meet allowable force to open have been corrected to allow for proper force per lbs to open. Last door provided with proper exit signage in place.<br>2) Reprograming of doors initiated and door adjustments initiated to meet force per lbs to open.<br>3) Education provided to maintenance | |

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| K 222 | Continued From page 5<br>indicating a delayed-egress system. Upon applying force to the door, it was observed that the delayed-egress initiated its countdown sequence to release. However, when force was released from the door it was observed that the delayed-egress system deactivated, and did not continue an irreversible process to release the lock. Additionally, it was observed that the force required to activate the delayed-egress system exceeded the maximum allowable force of 15 lbf. This condition was also observed at all but one of the exterior exits including the main entrance, which was also provided with a wonder guard system.<br><br>Observation on 10/18/2022 at 2:30 PM of the exterior exit located adjacent to room 104 revealed that the door was provided with signage indicating a delayed-egress system. Upon applying force to the door it was observed that no countdown sequence would initiate. Interview with the facility maintenance manager revealed that the system had been removed, but the signage was still in place. Additional observation revealed that the door required a much greater force than the maximum allowable 35 lbf. to open the door.<br><br>Interview with the facility maintenance manager at the time of the observation acknowledged each deficiency, and indicated he was not aware of the requirement.<br><br>Interview with the CEO at the time of exit acknowledged the deficiencies.<br><br>REF: 2012 NFPA 101, Sections 19.2.2.2.4(2) and 7.2.1.6.1.1(4) | K 222 | director in regards to delayed egress and proper force per lbs. for egress doors. Audits completed monthly to ensure egress doors compliance.<br>4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months<br>5) AOC Date: 11/18/22 | |
| K 321 SS=D | Hazardous Areas - Enclosure | K 321 | | 10/25/22 |

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| K 321 | Continued From page 6<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>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.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the faclity failed to protect hazardous storage locations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to protect hazardous areas as required could result in injury or death. The deficiency could affect all staff, residents, | K 321 | 1) Identified kitchen storage room provided to door.<br>2) Installation completed 10/25/22<br>3) Education to maintenance director on hazardous storage area and door requirements for identified area. | |

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| K 321 | Continued From page 7<br>and visitors within the vicinity of the noted location. The findings were:<br><br>Observation on 10/18/2022 at 2:02 PM of the kitchen storage room revealed that the room contained large quantities of combustible materials. Additional observation revealed that the room was sprinklered, and enclosed with construction that would limit the transfer of smoke, but that the door was not provided with a self- or automatic-closing device.<br><br>Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated he was unaware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiencies.<br><br>REF: 2012 NFPA 101, Sections 19.3.2.1 and 19.3.2.1.3. | K 321 | 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months<br>5) AOC Date: 10/25/22 | |
| K 345 SS=D | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain fire alarm systems in | K 345 | 1) Identified fire certificate of compliance had been conducted by Avantguard | 11/10/22 |

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| K 345 | Continued From page 8<br>accordance with the 2012 NFPA 101, Life Safety Code, and the 2010 NFPA 72, National Fire Alarm Code. Failure to maintain fire alarm systems as required could result in system failure during an emergency, which could affect all staff, residents, and visitors throughout the facility. The findings were:<br><br>Observation on 10/18/2022 at 1:07 PM of the fire alarm control panel located in the administrator's office revealed that the required UL certificate for indication of a central station service had expired on 03/31/2022. Interview with the facility maintenance manager and facility administrator at the time of the observation revealed that they were not aware of the certificated expiration.<br><br>Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was aware of the requirement.<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2010 NFPA 72, Section 26.3.4 | K 345 | monitoring centers LLC for the year of 2022 and requested certificate supplied to facility.<br>2) Certificate Posting □ 11/10/22<br>3) Education to maintenance director and ED in regards to annual certification of compliance and proper posting of form. Fire certificate and compliance to be completed annually.<br>4) Results of initial and ongoing audits will be reviewed via the QAPI process annually<br>5) AOC Date: 11/10/22 | |
| K 351 SS=E | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for | K 351 | | 11/18/22 |

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| K 351 | Continued From page 9<br>sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain sprinkler systems in accordance with the NFPA 101, Life Safety Code, and 2010 NFPA 13, Standard for the Installation of Sprinkler Systems. Failure to provide sprinkler systems as required could result in an increased risk of fire, resulting in injury or death during an emergency. The deficiency affected the attic area throughout the facility. The findings were:<br><br>Observation on 10/18/2022 at 2:05 PM of the attic area, via an access panel located within the hall to the shower room by the frontier nurses station revealed that large quantities of roof insulation had become unattached from the underside of the roof, and had fallen to the upper side of the ceiling. In many instances, the insulation had fallen on, or adjacent to, sprinkler heads throughout the attic. This condition may prevent activation of the sprinkler system due to a lack of heat reaching the sprinkler head, and may obstruct the flow pattern of the sprinkler.<br><br>Interview with the facility maintenance manager at the time of the observation acknowledged the deficiency, and indicated awareness of the condition and requirements. | K 351 | 1) Identified area where roofing insulation had fallen down in attic area covering or around sprinkler heads in area. Installation removed from immediate area to give sprinkler system full function<br>2) Audit completed in identified area with removal of insulation but further inspection showed areas affected that need to be cleared out as well.<br>3) Education provided to maintenance director on continuing to monitor attic area for any impedance of sprinkler system. Audit to be completed once a week for two weeks then monthly for 2 months.<br>4) Results of initial and ongoing audits will be reviewed via the QAPI process for three months<br>5) AOC Date: 11/18/22 | |

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| K 351 | Continued From page 10<br><br>Interview with the facility administrator at the time of exit acknowledged the deficiency.<br><br>REF: 2012 NFPA 101, Sections 19.3.5.1 and 9.7<br>2010 NFPA 13, Section 8.5.5 | K 351 | | |