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 _____	10/20/2022

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 recertification survey was conducted by Healthcare Licensing and Surveys from 10/17/22/22 to 10/20/22. In addition, a review for compliance with the Omnibus COVID-19 Health Care Staff Vaccination requirements was conducted. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the vaccine requirements. The following common abbreviations are used throughout this document: DON- Director of Nursing RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		11/11/22

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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F 623	Continued From page 1 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 2	F 623		

hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a written notice of transfer to 1 of 4 sample residents (#17) reviewed for a facility-initiated transfer. The findings were: 1. Review of the medical record for resident #17 showed the resident was hospitalized on 8/11/22 for evaluation and treatment for "Geripsych." There was no evidence a written transfer notice was provided to the resident or resident's representative. 2. Interview with the DON on 10/19/22 at 5:24 PM revealed the facility was unable to locate the form for the discharge/ transfer. Further, she stated the resident knew about the discharge/transfer and wanted to go.	F 623	1) Identified resident #17 has provided a signed a written transfer notice for the transfer on 8/11/22 2) Audit completed to identify any other residents not having written transfer notices with no other residents identified. 3) Education provider to nursing staff related to any resident being transferred, discharged to hospital or other continued care outside of facility needs to have a verbal notification of transfer and then a written copy to be supplied to family or POA to be signed. DNS/ Designee will provide ongoing audits, 1 audit weekly for 4 weeks then monthly for 1 month. 4) Results of initial as well as ongoing audits will be reviewed via the QAPI process monthly for three months for further recommendations. 5) AOC Date: 11/11/22	
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 732		11/11/22

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F 732	Continued From page 4 (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of daily staffing records, and staff interview, the facility failed to accurately post daily nurse staffing data. The census was 40. The findings were: 1. Review of the "Daily Staffing for Nursing" sheets for 10/6/22 through 10/18/22 failed to show the actual hours worked by the registered nurses, licensed practical nurses, and the certified nurse aides responsible for resident care per shift. 2. Interview with the administrator on 10/19/22 at 12:05 PM confirmed the daily staff posting failed	F 732	1) Identified staffing sheets updated day of survey to show actual hours worked by registered nurse, licensed practical nurses, and certified curse aides responsible for resident care 2) Updated sheet provided to show clearly actual hours of nursing staff 3) Education provided to ED, DNS, and SDC in regards to correct format of new form that shall include actual hours worked by nursing staff. Ongoing audits to be completed by ED, DNS, SDC, or designee twice a week for one week, then 1 time a week for four weeks to review	

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F 732	Continued From page 5 to include the actual hours worked by the resident care staff.	F 732	new staffing sheets are filled out appropriately every single day 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months for further recommendations. 5) AOC Date: 11/11/22	
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 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	F 761	1) Identified Humalog KwikPens without	11/11/22

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F 761	Continued From page 6 manufacturer's instructions, the facility failed to ensure medications available for use were not expired in 1 of 3 medication storage units (rehabilitation hall cart). The findings were: 1. Observation on 10/19/22 at 11:22 AM of the rehabilitation hall medication cart showed 2 humalog 100 units/milliliter (ml) kwikpens without a written open date. Interview with RN #1 at that time confirmed the medications were not dated and were for resident use. 2. Interview with the DON on 10/19/22 at 11:29 AM revealed it was the facility's expectation for the nurses to put an open date on insulin pens when they were removed from the refrigerator and then dispose of them when the medication expired. Further, she revealed the facility did not have a policy of medication expiration. She stated "...the nurses are to follow what the pharmacy says." 3. Review of manufacturer's instructions for Humalog KwikPens found at http://www.humalog.com/taking-humalog/using-u100-u200-kwikpen#storage-and-disposal-kwikpens, retrieved 10/20/22, showed "...Opened Humalog prefilled pens must be thrown away 28 days after first use, even if they still contain insulin..."	F 761	written open date were immediately disposed of. 2) Audit completed on 11/3/22 by DNS / designee showed that 1 Humalog KwikPens were opened without a written date. Both disposed of and no adverse effects from open Humalog KwikPens without dates. 3) Education for all nursing staff in regards to opening new medications and labeling open date properly to stay compliant with expiration of medications. Audit to be conducted by DNS / designee of medication carts two times a week for one week then one time a week for four weeks. 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months for further recommendations. 5) AOC Date: 11/11/22	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national	F 803		11/11/22

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F 803	Continued From page 7 guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of the menu, staff and resident interview, and medical record review, the facility failed to follow the controlled carbohydrate (CCHO) diet menu for 9 of 9 residents (#1, #4, #5, #6, #7, #10, #12, #13, #16) observed who required that diet. The findings were: 1. Review of medical records showed the following diet orders: a. Resident #1 had an order for a CCHO diet dated 9/15/22. b. Resident #4 had an order for a CCHO diet dated 10/16/19. c. Resident #5 had an order for a CCHO diet dated 7/26/22.	F 803	1) Residents 1, 4, 5, 6, 7, 10, 12, 13 and 16 identified with having sweet potatoes that were not supposed to be served to residents with a CCHO diet. 2) Identified residents showed no adverse effects form consumption of the sweet potatoes. 3) Education provided by the RD and DM on menu spreadsheet compliance. The DM or appointee will review and complete the tray line to menu spreadsheet audit to assure appropriate items are served per therapeutic diet order on 15 residents per week with documentation for 1 month. (5 residents, 3 times a week). After one month of	

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F 803	Continued From page 8 d. Resident #6 had an order for CCHO diet dated 9/2/22. e. Resident #7 had an order for a CCHO diet dated 8/18/22. f. Resident #10 had an order for a CCHO diet dated 7/21/17. g. Resident #12 had an order for a CCHO diet dated 10/11/22. h. Resident #13 had an order for a CCHO diet dated 7/6/22. i. Resident #16 had an order for a CCHO diet dated 3/15/22. 2. During an interview on 10/18/22 at 9:15 AM resident #5 stated the facility did not always follow his/her diabetic diet during meals. 3. Review of the menu for the lunch meal on 10/19/22 (signed by the certified dietary manager and registered dietitian on 9/14/22) showed the main meal consisted of a chicken filet sandwich, sweet potato fries, cucumber tomato salad, and a fruit tart. Review of the menu for the CCHO diet showed sweet potato fries were not to be served, and canned fruit was to replace the dessert. The following concerns were identified: a. Observation of the trayline in the kitchen on 10/19/22 from 11:51 AM until 12:21 PM showed cook #1 served sweet potato fries to the nine residents who had CCHO diets (#1, #4, #5, #6, #7, #10, #12, #13, #16). b. During an interview on 10/19/22 at 12:26 PM cook #1 and the certified dietary manager (CDM) both confirmed that sweet potato fries were served to residents with a CCHO diet. The CDM stated the menu did show that sweet potato fries should have been omitted for the CCHO diet. The CDM further stated this was a new menu and this was the first time this meal had	F 803	compliance, the DM will complete the tray line to menu spreadsheet audit on 10 residents per week for one month. (5 residents, 2x/week). 4) Results of initial and ongoing audits will be reviewed via the QAPI process monthly for three months for further recommendations. 5) AOC Date: 11/11/22	

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F 803	Continued From page 9 been served, but acknowledged that staff should have reviewed and followed the menu.	F 803		