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 _____	R **01/11/2023**

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
{K 000}	INITIAL COMMENTS A Life Safety Code revisit survey was conducted by Healthcare Licensing and Surveys on 01/11/2023. 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. 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 residents. The findings that follow demonstrate noncompliance with CFR 483.90.	{K 000}		
{K 211} SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain the means of egress	{K 211}	K211: 1. The exterior areas around the building were immediately cleared of snow. 2. Facility exterior walking surfaces	1/12/23

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

Electronically Signed | 02/06/2023

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 211}	Continued From page 1 could delay egress of occupant during an emergency, which may lead to injury or death. The deficiency affected two (2) of multiple exits from the building, and could impact all residents, staff and visitors. The findings were: Observation on 01/11/2022 at 8:35 AM of the exterior sidewalks around the exterior of the building revealed that snow had not been cleared from the walking surfaces. Snow coverage ranged from a light dusting to drifting of approximately two (2) to three (3) inches. The deepest drifting was observed at the sidewalks and parking lot surface used to access the public way from the north to west side of the building. Interview with the facility maintenance manager at the time of observation acknowledged the deficiency. He indicated that a snow removal service was under contract to clear snow from the parking lot and walkways, but that they are located in a nearby town and needed to complete other work before arriving at the facility. The surveyor advised that access to the public way must be maintained at all times. Interview with the director of nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 7.1.10.1	{K 211}	were checked to ensure compliance and regulations. 3. ED, Maintenance Director, and DON were educated on appropriate exterior areas to be clear of snow. 4. The Maintenance Director/Designee will audit the exterior walking surfaces daily for 4 weeks then monthly for 2 months. Results of audit will be discussed at the facility monthly Quality Assurance Performance Improvement Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. 5. Date of compliance 1/12/2023.	
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for	K 753		1/12/23

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K 753	Continued From page 2 product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide non-combustible decorations in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide non-combustible decorations could contribute to fuel load in the event of a fire, which may result in injury or death. The deficiency had the potential to impact residents, staff, and visitors in the impacted area. The findings were: Observation on 01/11/2023 at 8:55 AM in the entrance lobby revealed an artificial christmas tree located immediately inside the entrance doors. Interview with the facility maintenance manager at the time of the observation revealed that the tree has been in use during the holiday season for many years, and that no information was available to demonstrate that the tree was constructed of flame-retardant materials, or that the tree had been treated with a flame-retardant coating. Additional observation in the lobby revealed several artificial wreaths that had been taken down, and were stacked along the wall sitting against the baseboard heating element.	K 753	K753 1. The observed items were immediately removed and disposed of. 2. The facility was inspected to ensure compliance. 3. ED, Maintenance Director, and DON were educated of flame-retardant and decoration placement to ensure compliance. 6. Maintenance Director/designee will audit facility weekly for 4 weeks, then monthly for 2 months to ensure that decorations maintain compliance. Results of audit will be discussed at the facility monthly Quality Assurance Performance Improvement Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. 4. Date of compliance 1/12/2023.	

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K 753	Continued From page 3 Interview with the facility maintenance manager at the time of observation acknowledged the deficiency, and indicated he was not aware of the requirement. Interview with the director of nursing at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 19.7.5.6	K 753		