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 _____	C 11/16/2023

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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 11/13/23 to 11/16/23. Also reviewed in the course of the survey were complaint intakes WY000003630, WY000003706, and WY000003671. The following common abbreviations are used throughout this document: BIMS- Brief Interview for Mental Status CNA- Certified Nursing Assistant DON- Director of Nursing Services MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced	F 600		

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

Electronically Signed | 12/13/2023

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F 600	Continued From page 1 by: Based on observation, medical record review, staff interview, facility incident and employee record review, and review of facility policies and procedures and facility monitoring documentation, the facility failed to protect the resident's right to be free from verbal abuse and physical abuse by staff for 1 of 3 sample residents (#10) reviewed for abuse allegations. Corrective measures were implemented by the facility prior to the survey and compliance was determined to be met on 10/29/23. The findings were: 1. Review of a quarterly MDS assessment dated 10/13/23 showed resident #10 had a BIMS score of 6 out 15, which indicated severe cognitive impairment, and diagnoses which included non-Alzheimer's dementia, malnutrition, anxiety disorder, gastrointestinal hemorrhage, and diverticulosis of the large intestine without perforation, abscess, or bleeding. Further review showed the resident required moderate assistance (helper does less than half the effort) with eating, had weight loss which was not physician prescribed, and was on a mechanically altered diet. Review of the care plan related to the resident's refusal to eat, resistance to assistance with eating, and decreased appetite last revised on 8/3/23 showed interventions which included family provided snacks and favorite food items, allowing choices related to meal time, menu selection, and dining location, invitations to food related activities, and monitor/document circumstances surrounding mealtimes/refusals to eat. Review of the care plan related to a psychosocial well-being problem due to dementia and depression last revised on 9/13/22 showed interventions which included allowing the resident time to answer questions and verbalize feelings,	F 600	Past noncompliance: no plan of correction required.	

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perceptions and fears as needed. The following concerns were identified:

a. Review of a facility incident report dated 10/21/23 showed CNA #1 allegedly told resident #10 "take another bite or I will make you have 3 more" and grabbed the resident's cheeks to put more food in the resident's mouth. The resident's response was to yell for help. Further review showed when another staff member stopped the interaction, CNA #1 "yelled profanities and was acting inappropriately." CNA #1 was placed on leave pending investigation and terminated when the investigation was concluded.

b. Review of a progress note dated 10/21/23 and timed 1:24 PM showed "CNA reported alleged verbal and physical abuse against resident by another CNA during lunch. Reporting CNA witnessed alleged offending CNA pinched resident's cheek and tried to force [his/her] mouth open to take another bite. Reporting CNA then stated she used the spoon to try and keep the food in [his/her] mouth when resident tried to spit it out. This RN overheard alleged offending CNA state "if you don't take a bite, I will put 3 more in there." CNA was told to leave the table away from resident and then removed from the building. Resident assessed for injury, no redness, swelling, or other injury noted to resident's face or mouth. Abuse coordinator, MD and family notified."

c. Review of a progress note dated 10/22/23 and timed 2:11 AM showed "Resident had no bruising to face at this time. No c/o [complaints of] pain to chin or cheek. Resident voiced being frightened r/t [related to] incident in dining room at lunch. "I thought she was going to kill me" Resident asked this writer to check on the resident frequently throughout the night."

d. Review of a progress note dated 10/23/23

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and timed 11 AM showed "ED [executive director] and DON talked to resident and completed a safety survey. No concerns from the interview. When asked if [s/he] has ever felt uncomfortable or scared at any meals times, [resident] stated yes and that [s/he] could not remember what happened but [s/he] remembers a staff member making her feel scared. This staff reassured resident that the staff member who made [him/her] feel this way, would no longer provide [him/her] cares and that [s/he] would not have to see them as they no longer work here. [The resident] responded "oh really?" when asked how that made [him/her] feel, [s/he] said "Much better, I feel safe here" [the resident] stated [s/he] feels comfortable reporting concerns, staff treat [him/her] with respect, [s/he] currently feels safe and comfortable, and decline anyone inappropriately touching [him/her]. [The resident] will stay on increased monitoring to ensure physical and psychosocial well-being and safety."

e. Interview with CNA #1 on 11/16/23 at 8:39 AM confirmed she was terminated from the facility for the allegation; however, she denied the incident occurred.

f. Interview with RN #1 on 11/16/23 at 9:01 AM confirmed she was on shift the day of the incident and revealed she heard CNA #1 tell resident #10 "I need you to take another bite or I'm going to give you 3 more." The nurse revealed as she was going to the dining room following the statement she heard CNA #2 tell CNA #1 what she was doing was not acceptable and to stop. The RN revealed CNA #2 reported CNA #1 was pinching the resident's face and the resident's mouth was full of food. The RN confirmed she told CNA #1 she needed to leave the facility at that time and the CNA responded by saying everyone fed the resident that way. The RN

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revealed the resident appeared shaky and upset following the incident.

g. Interview with CNA #2 on 11/16/23 at 9:36 AM confirmed the incident happened during lunch and she observed CNA #1 hold resident #10's cheek and force food into his/her mouth. CNA #2 revealed she attempted to politely tell CNA #1 she couldn't force the resident to eat and the resident was yelling for help. The CNA revealed when she observed the resident's mouth was full of food, she attempted to get CNA #1 stop for a second time; however, the CNA told her to mind her own business. CNA #2 revealed at that time, she stood and asked the resident if s/he was done eating and the resident said yes. The CNA revealed she observed CNA #1 attempt to prevent the resident from spitting food out by placing a spoon in front of the resident's mouth to block the spitting. She revealed when she assisted the resident out of the dining room and back to his/her room, the resident told her thank you for saving his/her life. CNA #2 confirmed she reported the allegation to the charge nurse and CNA #1 was placed on suspension, then terminated from the facility.

h. Interview with CNA #3 on 11/16/23 at 9:46 AM revealed she heard CNA #1 tell resident #10 to take another bite or she would shove 4 more down his/her throat. Further interview revealed she heard the resident yell which did not normally happen; however, when she turned around she did not observe anything abnormal.

2. Interview with the DON, ED, and divisional director of clinical operations on 11/16/23 at 10:07 AM confirmed the allegation of abuse was reported and investigated. They confirmed as a result of the investigation, CNA #1 was terminated from the facility. Review of the

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employee record verified the termination. They revealed resident #10 did not have a change in baseline feelings as a result of the incident. Observations during the survey showed no evidence of ongoing physical or mental outcome as a result of the incident. They revealed residents were interviewed for additional allegations of abuse and resident safety, and staff education was performed from 10/25/23 through 10/29/23 related to abuse and neglect. Review of the incident investigation verified resident interviews were completed and the education sign in sheet verified the completion of the training. They revealed the leadership team was conducting monitoring through manager on duty meal supervision, daily leadership rounding with documentation of rounding performed twice per week with notes related to safety, abuse observations, resident concerns, and random audits of staff knowledge of abuse through clinical scenarios which were reported to QAPI. They revealed monthly abuse reporting audits were also performed and reported to QAPI. Review of the meal monitoring schedule and training initiated on 2/28/23, leadership rounds for November 2023, and random staff audits for November 2023 verified the completion of ongoing monitoring. Observations during the survey verified meal monitors were present during meals.

3. Review of the facility policy titled "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation" last updated October 2022 showed "...Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, involuntary

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F 600	Continued From page 6 seclusion, mistreatment, neglect, misappropriation of resident property, exploitation, and any physical or chemical restraint not required to treat the resident's medical condition. The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members, and others who may have unsupervised access to residents. These policies address screening, training, preventions, identification, investigation, protection, and reporting/response..."	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		1/1/24

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F 656	Continued From page 7 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident and staff interview, and policy and procedure review the facility failed to develop comprehensive care plans for 1 of 12 sample residents (#39). The findings were: 1. Review of the quarterly MDS assessment dated 9/29/23 showed resident #39 had an admission date of 4/18/23, a BIMS score of 7 out of 15, which indicated severe cognitive deficits, and diagnoses which included non-Alzheimer dementia, anxiety, and depression. The following concerns were identified: a. Observation on 11/13/23 at 4:17 PM showed the resident was packing his/her bags. At that time, s/he stated s/he was getting discharged	F 656	1) Resident #39□s care plan was immediately updated to meet compliance. 2) Facility audit complete to validate care plans meet compliance. 3) Staff educated on care plan regulations to meet compliance. 4) The DON/Designee will audit care plans weekly for 3 months. Results of the audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on	

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F 656	Continued From page 8 and was ready to go home. Observation on 11/15/23 at 9:53 AM showed the resident was located in the front hall by the main entrance and had just got his/her nails painted. At that time, the resident stated the bracelet on his/her left wrist was an alarm and would go off if s/he goes out the door. b. Review of the physician orders showed "Device: Wander guard every shift" with an active date of 8/14/23. c. Review of the "Elopement/Exit-Seeking Evaluation" dated 8/18/23 for the resident showed -Wanders, verbalizes desire to go home, has dementia and attempts to leave the facility at times in belief she is okay to go home. There were no interventions identified and no indication of the wander-guard use. d. Review of the care plan last revised on 11/1/23 showed the resident had dementia and confusion; however, there was no care plan developed for wandering or elopement. 2. Interview with DON on 11/16/23 at 8:24 AM revealed anyone with dementia and is at risk of elopement or exit seeking, or verbal exit seeking would get a wander-guard and the facility would care plan it. 3. Review of the policy and procedure "Devices" hand delivered by the DON on 11/16/23 at 9:10 AM showed "...2. e. Are addressed on the care plan and updated appropriately..."	F 656	results. 5) 1/1/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		1/1/24

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 10 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure appropriate hand hygiene and glove use to prevent cross-contamination for 1 of 2 sample residents (#19) observed during perineal care. The findings were: 1. Review of the annual MDS assessment dated 10/26/23 showed resident #19 had a BIMS score of 12 out 15, which indicated the resident was cognitively intact, and diagnoses which included non-traumatic brain dysfunction, depression, Wernicke's encephalopathy, muscle weakness, and other symptoms and signs involving cognitive	F 880	1. Immediate correction and edcaution provided to staff to validate infection control compliance related to resident #19. 2. Facility audit complete to validate infection control protocol to meet compliance 3. Staff educated on infection control regualtions to meet compliance. 4. The DON/Designee will audit infection control pratices weekly for 3 months. Results of the audits will be discussed at	

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F 880	Continued From page 11 functions and awareness. Further review showed the resident was dependent on staff for toileting hygiene. The following concerns were identified: a. Observation on 11/15/23 at 4:16 PM showed CNA #4 removed the resident's brief and performed perineal care on the resident, who was incontinent of urine, by wiping front to back. The CNA assisted the resident to roll to his/her left side, placed a clean brief under the resident, and performed perineal care to the resident's buttocks by wiping front to back. After finishing perineal care, the CNA attached the brief tabs, then pulled up the resident's pants and blanket. No glove change was performed before touching the clean items. b. Interview with CNA #4 on 11/15/23 at 4:23 PM confirmed the resident was incontinent of urine and revealed staff should remove gloves after performing perineal care, prior to touching anything else, to prevent cross contamination. 2. Interview with the DON on 11/15/23 at 4:32 PM revealed staff should perform glove changes when going from dirty to clean, including after perineal care to a resident who was incontinent of urine. 3. Review of the policy titled "Standard Precautions" provided by the DON on 11/15/23 at 4:40 PM showed "...e. Change gloves, as necessary, during care of a resident to prevent cross-contamination from one body site to another(when moving from a "dirty" site to a "clean" one)..."	F 880	monhtly QAA/QAPI meeting to determine correction compliance and discussion of contonues or discontinuation of audits based on results. 5. Date of compliance 1/1/2024.	