

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025	
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			E 000			
	An emergency preparedness survey was conducted by Healthcare Licensing and Surveys on 02/12/2025. Based on the findings of the survey, it was determined that the facility was in compliance with all requirements in accordance with 42 CFR 483.73.						
K 000	INITIAL COMMENTS			K 000			
	A Life Safety Code survey was conducted by Healthcare Licensing and Surveys on 02/12/2025.						
	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 (000) 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 53 residents. The findings that follow demonstrate noncompliance with CFR 483.90.						
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101			K 200			3/5/25
	Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/10/2025

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 200	Continued From page 1 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain door leaf encroachment within the means of egress in accordance with the 2012 NFPA 101, Life Safety Code. Failure to maintain door leaf encroachment as required could result in the delay of occupant egress during an emergency, which could result in injury or death. The deficiency affected one of numerous doors opening to the corridor throughout the facility. The findings were: Observation on 02/12/2025 starting at 12:08 PM at the PT closet revealed that the doors opened into the corridor, and would not swing to the full-open position, which could impede the required width of the means of egress. Observation revealed the left leaf of the double doors impacted the corridor handrail, and opened to approximately 18 inches from the wall in the full-open position. Interview with the facility maintenance manager and regional maintenance director at the time of the observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.2.2.2.1 and 7.2.1.4.3.1	K 200	Sage View Annual Survey 2/12/2025 Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. POC: Annual Survey- K200- Means of Egress Requirements- Other CFR(s): NFPA 101 Date:2/12/25 1. The Maintenance Director shortened the handrail that was affecting the means of egress to be able to have the PT closet door swing open to the full position. 2. The Maintenance Director or designee will audit corridor doors to identify doors that are affected by the means of egress. Doors affected will be corrected to allow the door to swing open to this full position.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 200	Continued From page 2	K 200	3. Education was provided by the Executive Director to the DON and Maintenance Director on validating doors are able to swing to full open position. Verbal communication monthly with Maintenance Director or designee to validate if Handrails were installed that could potentially affect the means of egress. 4. The Director of Maintenance or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. Date of compliance is 3/05/2025		
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 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.	K 222			3/4/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 3 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 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	K 222			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 4 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 provide egress doors in accordance with the 2012 NFPA 101, Life Safety Code. Failure to provide egress door as required could result in delayed egress from the facility during an emergency, which may result in injury or death. The deficiency could impact all residents, staff, or visitors attempting to utilize the exit. The findings were: Observation on 02/12/2025 at 12:13 PM of the exterior exit at the PT area revealed that the door was provided with a delayed egress system. Attempts to activate the delayed egress system revealed that it would not enter an irreversible process that released the lock in the direction of egress without applying a force in excess of 15 lbf. Interview with the facility maintenance manager and regional maintenance director at the time of observation confirmed the deficiency, and indicated they were aware of the 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, and 7.2.1.6.1	K 222	POC: Annual Survey- K222 ☐ Egress Doors Date:2/12/25 1. The Maintenance Director was able to adjust the plate on the egress system of the exterior exit at the PT area door so that the delayed egress system would be able to enter its irreversible process. 2. The Maintenance Director or designee will audit the exterior exit doors with a delayed egress system 1x per week for 12 weeks. Doors affected will be corrected to allow the appropriate amount of pressure applied to the door to enable the delayed egress system to enter its irreversible process. 3. Education was provided by the Executive Director to the DON and Maintenance Director on validating that all doors with the delayed egress system are able to enter the irreversible process under 15 lbs. Maintenance Director or designee will complete a 1x per week audit of exit doors to validate doors with delayed egress systems release with less than 15lbs of pressure. 4. The Director of Maintenance or designee will report the tracking and trending of the audits to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 222	Continued From page 5	K 222	committee.		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING 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. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. 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. 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) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 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 of the facility. The findings were: Observation on 02/12/2025 starting at 11:12 AM of the attic area, via an access panel located near	K 351	5. Date of compliance 3/4/2025 POC: Annual Survey- K351 Sprinkler Installation Date:2/12/25 1. Contractor removed fallen insulation from the affected sprinkler areas and rewired cabling and co-ax cabling so that it does not come into contact with the sprinkler system in the attic. 2. The Maintenance Director or designee visually inspected the attic space for fallen insulation onto the sprinkler systems as well as any cabling		3/31/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 351	Continued From page 6 the MDS office, revealed that large quantities of roof insulation had become unattached from the underside of the roof, and have fallen to the upper side of the ceiling. In many instances, this insulation has 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. Additionally, large quantities of IT cabling and co-ax cabling were observed to be suspended from, or draped over, sprinkler piping throughout the attic. Interview with the facility maintenance manager and regional maintenance director at the time of the observation confirmed the deficiency, and indicated awareness of the condition and requirements. Interview with the facility administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Sections 19.3.5.1 and 9.7 2010 NFPA 13, Section 8.5.5	K 351	and Co-ax cabling blocking the sprinkler system. Results of the visual inspection were discussed with the contractor for correction. 3. Maintenance Director or designee will audit monthly x3 months any contractor who performs work in the attic area to validate that the insulation and co-ax cabling do not affect the sprinkler system. Education was provided by the Executive Director to the Maintenance Director on ensuring that insulation and wiring are not affecting sprinkler systems in the attic. 4. The Director of Maintenance or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. 5. Date of compliance 3/31/2025		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		3/31/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 372	Continued From page 7 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain openings in smoke barriers in accordance with the NFPA 101, Life Safety Code. Failure to maintain smoke barriers as required could result in an increased risk of fire and smoke spread, resulting in injury or death during an emergency. The deficiency affected the attic area of the facility. The findings were: Observation on 02/12/2025 at 11:12 AM of the attic space revealed a smoke barrier located adjacent to the MDS office. Further observation revealed that an access panel was provided in the smoke barrier to cross between adjacent smoke barriers. The opening protection consisted of several layers of gypsum board, and was bolted or screwed in place. Further observation revealed that multiple bolts or screws had been removed, and the opening protection was loose, which resulted in an unprotected opening within the smoke barrier. The surveyor was able to see into the adjacent smoke compartment through the opening. Openings in smoke barriers must be protected with an approved system to maintain continuity of the smoke barrier at all times. Interview with the facility maintenance manager and regional maintenance director at the time of the observation confirmed the deficiency, and indicated awareness of the requirements, but that they were unaware of the condition. Interview with the facility administrator at the time	K 372	POC: Annual Survey- K372 Smoke Barrier Date:2/12/25 1. Opening in the smoke barrier in the affected area adjacent to the MDS office was repaired. 2. The Maintenance Director or designee will complete an audit of smoke barriers to validate they are sealed appropriately. Affected smoke barriers will be corrected by Maintenance Director or designee. 3. Education was provided by the Executive Director to the Maintenance Director to validate smoke barriers are properly sealed. The Maintenance Director or Designee will audit monthly x3 months any contractor who performs work in the attic area to validate smoke barriers are properly sealed. 4. The Director of Maintenance or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee. 5. Date of compliance 3/31/2025		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 372	Continued From page 8 of exit acknowledged the deficiency.	K 372			
K 712 SS=E	REF: 2012 NFPA 101, Sections 19.3.7.3 and 8.5 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to perform fire drills in accordance with the 2012 NFPA 101, Life Safety Code. Failure to perform fire drills as required could result in staff and residents being unprepared in the event of an emergency, resulting in injury or death. The deficiency affect all staff and residents within the facility. The findings were: Document review on 02/12/2025 starting at 1:00 PM revealed that the facility had performed fire drills once per shift per quarter for the months of February 2024 through June of 2024. Further observation revealed that the facility had performed monthly fire drills for the months of July 2024 through January 2025, but that all drills had been performed during the day shift only. Fire	K 712	POC: Annual Survey- K712 Fire Drills Date:2/12/25 1. The Maintenance Director performed a fire drill during the night shift on 2/28/25. 2. Education was provided by the Executive Director to the DON and Maintenance Director on validating that the facility performs fire drills once per shift per quarter. 3. The Executive Director or designee will audit fire alarm drills monthly for 3 months to validate that the facility has performed fire drills once per shift per quarter on all shifts. 4. The Director of Maintenance or designee will report the tracking and trending of the random review to the facility monthly Quality Assurance Meeting	3/5/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER SAGE VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 712	Continued From page 9 drills must be conducted once per quarter per shift. Interview with the facility maintenance manager and regional maintenance director at the time of the observation confirmed the deficiency, and indicated they were aware of the requirement. Interview with the administrator at the time of exit acknowledged the deficiency. REF: 2012 NFPA 101, Section 19.7.1.6	K 712	for 90 days or until substantial compliance has been achieved or sustained as directed by the _____ committee. 5. Date of Compliance is 3/5/25.		