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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37603 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 [DATE] 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.

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.

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 37603 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 to include the actual hours worked by the resident care staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37603 Based on observation, staff interview, and review 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 .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 16146 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. 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 been served, but acknowledged that staff should have reviewed and followed the menu.