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	07/23/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 16146 Based on observation, medical record review, staff interview, and review of incident reports, facility documentation and manufacturer's instructions, the facility failed to provide adequate supervision to prevent an elopement for 1 of 2 sample residents (#1) reviewed for elopement. In addition, the facility failed to ensure the wander management system (wanderguard) was tested per manufacturer's instructions to ensure it was working. The facility had 11 residents with a wanderguard. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 7/5/24. 1. Review of the 6/24/24 admission Minimum Data Set (MDS) assessment showed resident #1 had a diagnosis of non-Alzheimer's dementia and wandered daily. Review of the 6/17/24 elopement/exit seeking evaluation showed the resident had a history of wandering and was at risk for elopement. Review of physician orders showed a 6/17/24 order for a wanderguard [bracelet that is worn and triggers an alarm when the resident is near an opened exit door]. Review of progress notes dated 6/22/24 to 6/29/24 showed the resident was exit seeking and had tried to leave out the front door on 6/28/24. The following concerns were identified: a. Review of an incident report dated 6/29/24 showed on 6/29/24 at 6:05 PM a Code [NAME] was initiated because the resident was unable to be located. The resident was last seen about 45 minutes prior walking the halls. Staff implemented their elopement protocol and the police were notified. The police department found the resident at his/her house about 30 minutes after the search began. The facility investigation showed a visitor of another resident had come to the facility, let resident #1 out, and gave the resident a ride home without the staff's knowledge. b. Interview with registered nurse (RN) #1 (nurse in charge at the time of the elopement) on 7/22/24 at 5:33 PM revealed on 6/29/24 about 6 PM she was notified resident #1 could not be located. She stated they started an inside and outside search and the police were notified. She stated the resident was found by police at his/her house. She stated a family member who had been outside the facility said she saw the resident get into a vehicle. The RN stated the resident's Wanderguard was working. She stated she and another nurse were in a resident's room doing a skin assessment when they heard the front door alarm. She stated licensed practical nurse (LPN) #1 responded to the alarm and shut it off. (continued on next page)

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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	535056	A. Building B. Wing	07/23/2024

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Interview with LPN #1 on 7/22/24 at 5:42 PM revealed she was working on the back hallway the day of the elopement. She stated she was in the middle of administering medications to a resident when she heard the front door alarm go off. She stated she finished giving the medications and went to the front door. She stated she looked outside and only saw a visitor sitting on the porch. She did not see any residents, so she turned off the alarm. Later, when staff realized the resident was missing, she called the visitor who had been sitting outside and was told she saw the resident leave with another person. Resident #1 asked the other person for a ride and the person agreed and they left in a vehicle. 2. Observation on 7/22/24 at 5 PM of the exit doors showed the facility used the Code Alert- 9450 wander management system (wanderguard). Review of documentation provided by the facility showed 11 residents currently utilized the wanderguard system, including sample residents #1 and #2. The following concerns were identified: a. Review of the July 2024 medication administration records (MARs) for residents #1 and #2 showed nursing staff checked placement of the wanderguard every shift. There lacked evidence the function of the wanderguard was checked. b. Documentation of resident Wanderguard checks to ensure function was requested. The facility provided evidence of weekly wanderguard checks for July 2024, but not earlier months. c. On 7/23/24 at 8:17 AM the administrator stated the maintenance staff was new as of 6/28/24. After the 6/29/24 elopement she asked him to find documentation of wanderguard checks from the previous maintenance staff, but he was unable to find any. She stated the facility did not have evidence of wanderguard checks for any of the residents prior to July. She stated weekly checks have been done since the beginning of July. d. Review of the RF Technology's Code Alert Wander Management Transmitters User Guide (https://www.rft.com/wp-content/uploads/2018/11/0510-1122-J_Code-Alert-Transmitter-User-Guide.pdf, accessed 7/26/24) showed weekly testing was required for transmitters in use on residents. 3. The following plan of correction was implemented by the facility by 7/5/24: a. Resident #1 was placed on 1:1 supervision until s/he was discharged to a facility with a secure unit. b. The facility implemented checks on all the wanderguards to ensure function, and continues weekly. c. The facility educated all staff on elopement prevention and elopement policy. This included a reminder to respond immediately to door alarms and the following instructions: If no resident is found, immediately investigate why the alarm went off. A head count needs to be completed on all residents. d. An elopement/wanderguard performance improvement project (PIP) was initiated 7/1/24. This includes audits for wanderguard testing and education to staff.