

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Sage View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>37603</p> <p>Based on staff schedule review, daily staff posting review, time punch history review, and staff interview, the facility failed to ensure an RN was on duty for 8 consecutive hours per day, 7 days per week. The census was 533. The findings were:</p> <ol style="list-style-type: none"> 1. Review of the February 2025 nursing schedule failed to show an RN had been scheduled for 2/8/25. 2. Review of the daily staff postings failed to show there was an RN on duty for 2/8/25. 3. Review of the time punch history for RN #1 showed on 2/8/25 she worked for 3.25 hours from 11:53 AM to 3:12 PM. 4. Interview with the DON on 2/12/25 at 1:49 PM revealed the RN on duty had been on-call and only worked 3.5 hours on 2/8/25. She stated she understood the nurse needed to be on duty for 8 hours; however, she confirmed the RN did not work 8 hours.

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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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>50485</p> <p>Based on medical record review, and resident, and staff interview the facility failed to provide rehabilitative services for 1 of 8 sample residents(#150). The findings were:</p> <p>1. Review of the initial care plan dated 1/24/25 showed resident #150 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, myocardial infarction, and weakness. Further review showed a physician's order dated 1/23/25 to evaluate and treat for physical and occupational therapy. The following concerns were identified:</p> <p>a. Interview with the resident on 2/11/25 at 8:40 AM revealed s/he had been in the facility for more than a week and had not received any therapy.</p> <p>b. Interview with the DON on 2/12/25 at 1:46 PM revealed she had been unaware that the resident had therapy orders and confirmed the resident had not received any therapy services.</p> <p>c. Interview with the DOR on 2/12/25 at 2:12 PM revealed she had been unaware the resident had therapy orders, and confirmed the resident had not received any therapy services.</p>