March 15, 2019

Debbie Mills, Administrator
Wellspring Health & Rehabilitation Of Cascadia
2105 12th Avenue Road
Nampa, ID  83686-6312

Provider #: 135094

Dear Ms. Mills:

On March 1, 2019, a survey was conducted at Wellspring Health & Rehabilitation Of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.
After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by March 25, 2019. Failure to submit an acceptable PoC by March 25, 2019, may result in the imposition of penalties by April 17, 2019.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by April 5, 2019 (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on May 30, 2019. A change in the seriousness of the deficiencies on April 15, 2019, may result in a change
The remedy, which will be recommended if substantial compliance has not been achieved by May 30, 2019 includes the following:

Denial of payment for new admissions effective June 1, 2019. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on September 1, 2019, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Laura Thompson, RN or Belinda Day, RN Co-Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on May 30, 2019 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:
Debbie Mills, Administrator
March 15, 2019
Page 4


go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

  2001-10 Long Term Care Informal Dispute Resolution Process
  2001-10 IDR Request Form

This request must be received by **March 25, 2019**. If your request for informal dispute resolution is received after **March 25, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Laura Thompson, RN or Belinda Day, RN Co-Supervisors Long Term Care at (208) 334-6626, option 2.

Sincerely,

Laura Thompson, RN, Co-Supervisor
Long Term Care
Bureau of Facility Standards

lt/dr
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
**Wellspring Health & Rehabilitation of Cascadia**

#### Street Address, City, State, Zip Code
2105 12th Avenue Road
Nampa, ID 83686

#### Statement of Deficiencies

**INITIAL COMMENTS**

The following deficiencies were cited during the federal recertification survey and complaint investigation conducted at the facility from February 25, 2019 through March 1, 2019.

The surveyors conducting the survey were:

- Linda Kelly, RN, Team Coordinator
- Jenny Walker, RN
- Wendi Gonzales, RN

**Abbreviations:**
- DNS = Director of Nursing Services
- BID = Twice a day
- BP = Blood pressure
- CHF = Congestive heart failure
- ESRD = End stage renal disease
- LPN = Licensed Practical Nurse
- MDS = Minimum Data Set
- mg = Milligram(s)
- PRN = As needed
- RN = Registered Nurse
- UM = Unit Manager

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
<th>CFR(s)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 568</td>
<td>SS=E</td>
<td></td>
<td>Accounting and Records of Personal Funds</td>
<td>483.10(f)(10)(iii)</td>
<td>4/5/19</td>
</tr>
</tbody>
</table>

**F 568**

§483.10(f)(10)(iii) Accounting and Records.

(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

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**

Electronically Signed

03/25/2019

---

**Form CMS-2567(02-99) Previous Versions Obsolete**

Event ID: 79C311
Facility ID: MDS001260
If continuation sheet Page 1 of 31
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 568</td>
<td>Continued From page 1</td>
<td></td>
<td>(C) The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on family and staff interview, and record review, it was determined the facility failed to provide a financial record, or quarterly statement, to 5 of 6 residents (#5, #6, #11, #37, and #49) whose personal fund accounts were reviewed. The failure created the potential for harm if concerns, including inaccuracies, about the personal fund accounts were not addressed. Findings include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1. Resident #6 was admitted to the facility on 9/2/10, with multiple diagnoses including dementia and adult failure to thrive. On 2/26/19 at 2:08 PM, Resident #6’s representative said the facility held a personal fund account for her but she had not received a quarterly statement for the account for about a year. On 2/27/19 at 2:29 PM, the Business Office Manager (BOM) said the facility held a personal fund account for Resident #6. The BOM said she did not keep a copy of Resident #6’s account statements or when she mailed them to Resident #6’s representative. On 2/27/19 at 3:31 PM, the BOM said Resident #6’s representative verified the facility had her correct mailing address and confirmed she had not received a fund account statement for about 1 year.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| F 568 | | | Resident Specific Residents #5, 6, 11, 37 and 49 had their individual financial record for the trust fund provided to them and/or personal representative. Documentation is maintained for business office records. Other Residents The business office manager or designee reviewed other residents with resident trust funds and provided copies of their personal quarterly financial statement. Documented evidence is maintained in the business office records. Facility Systems Business office manager was educated by Executive Director on requirement to provide at least quarterly statements and to maintain copy of date of mailing/delivery when indicated. They system is amended to include the Executive Director to review at least quarterly. Monitor The Executive Director and/or designee will audit residents with trust fund accounts quarterly statements. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the
### Statement of Deficiencies and Plan of Correction

**Date Survey Completed**: 03/01/2019

**Provider/Supplier/CLIA Identification Number**: 135094

**Declaration of Deficiencies and Plan of Correction**

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
</table>

**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
</tr>
</thead>
</table>

**Transfer and Discharge Requirements**

**CFR(s)**: 483.15(c)(1)(i)(ii)(2)(i)-(iii)

---

#### F 568

Continued From page 2

2. The facility did not have documentation personal fund account statements were provided to residents or their representatives for Resident #5, #11, #37, and #49.

On 2/26/19 at 2:08 PM, the BOM said she did not keep copies of residents’ personal fund account statements. She said the company that managed resident fund accounts sent quarterly statements to the facility for each resident who had an account. She said if the address on the statement was the same as the facility’s address, the statement was hand delivered to the resident, if the address was different from the facility’s address, the statement was mailed to the person addressed on the statement.

On 2/27/19 at 2:45 PM, the Administrator provided a list of 25 residents for whom the facility held a personal fund account. At 3:31 PM, the BOM reviewed the list and said she mailed personal fund account statements to the representative for 6 of the 25 residents. The BOM said she did not keep a record of when she mailed the fund account statements.

On 2/27/19 at 3:50 PM, the BOM provided a copy of Resident #49’s personal fund account statement for 10/1/18 to 12/31/18 with the name and address of her representative.

On 2/28/19 at 8:45 AM, the BOM said she did not have documentation she mailed quarterly personal fund account statements to the residents, or their representatives, who received the statements by mail.

**Date of Compliance**: 4/5/2019

---

### F 622

**Transfer and Discharge Requirements**

**Event ID**: Facility ID: MDS001260

**Event ID**: Facility ID: MDS001260

**If continuation sheet Page**: 3 of 31
### F 622

**Continued From page 3**

§483.15(c) Transfer and discharge-

§483.15(c)(1) Facility requirements-

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health...
F 622 Continued From page 4

or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c) (1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-

(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident.

(B) Resident representative information including contact information

(C) Advance Directive information

(D) All special instructions or precautions for
onsite care, as appropriate.

E) Comprehensive care plan goals;
(F) All other necessary information, including a
copy of the resident's discharge summary,
consistent with §483.21(c)(2) as applicable, and
any other documentation, as applicable, to
ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, it
was determined the facility failed to ensure
information was provided to the receiving hospital
for emergent situations for 3 of 4 residents (#2,
#39, and #52) reviewed for transfers. The
deficient practice had the potential to cause harm
if the residents did not receive the appropriate
care and services in a timely manner due to the
lack of information. Findings include:

1. Resident #2 was readmitted to the facility on
2/13/19, with multiple diagnoses including a heart
attack.

A discharge MDS assessment, dated 2/7/19,
documented Resident #2 was discharged to an
acute hospital.

A Nursing Progress Note, dated 2/7/19 at 5:58
AM, documented Resident #2 was not breathing,
no pulse was detected, CPR (cardiopulmonary
resuscitation) was initiated, and 911 was called.

Resident #2's record did not include
documentation his physician was notified or
information regarding his status was conveyed to
the hospital.

On 2/27/19 at 10:13 AM, UM #2 stated when a

F 622

F 622

F622

Resident Specific
Resident #2, 39, and 52, who are
currently in facility, will have the required
documentation completed and the
appropriate information communicated to
receiving facility if discharge should
occur. After review, no negative
outcomes were identified for these
residents.

Other Residents
All current residents will have the required
documentation completed and the
appropriate information communicated to
receiving facility if discharge should
occur. No current residents are in the
hospital. No additional documentation is
required.

Facility Systems
Licensed nurses were educated by
Director of Nurses or designee on facility
transfer and discharge policy including
but not limited to process to show
evidence of information shared with
receiving facility, documentation for
physician notification, and documentation of
communication shared with transport
### F 622

**Continued From page 6**

Resident #29 was transferred to an Emergency Room (ER) or hospital, the facility provided two copies of the resident's face sheet, medication list, H&P (History and Physical, contains medical history information and the physical assessment of the resident by a health care provider), change of condition, code status, and the order to transport to the ER/hospital. He said one copy went to the paramedics and the other copy was for the ER/hospital. The DNS and UM#2 stated Resident #29's record did not include documentation he was sent to the hospital via ambulance, clinical information/paperwork was provided to the paramedics or ER/hospital, or the reason for the transfer to the hospital.

**Monitor**

The Director of Nursing or designee will audit for completion of evidence in the clinical record of required documentation for residents who are transferred or discharged weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

**Date of Compliance**

4/5/2019

---

**F 622**

as indicated. The system is amended to include review in clinical meeting of the required documentation of residents who are transferred or discharged from facility that is evident in the clinical record.

Monitor

The Director of Nursing or designee will audit for completion of evidence in the clinical record of required documentation for residents who are transferred or discharged weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

**Date of Compliance**

4/5/2019

---

A discharge MDS assessment, dated 12/30/18, documented Resident #39 was discharged to an acute care hospital.

**Monitor**

The Director of Nursing or designee will audit for completion of evidence in the clinical record of required documentation for residents who are transferred or discharged weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

**Date of Compliance**

4/5/2019

---

A Nursing Progress Note, dated 12/30/18 at 4:34 PM, documented Resident #39 had a change of condition, the physician was notified and ordered to have Resident #39 transferred to the hospital for further evaluation.

Resident #39's record did not include documentation the hospital was notified of the transfer or information/paperwork regarding Resident #39's status was sent to the hospital.

On 2/27/19 at 1:59 PM, the DNS stated Resident #39's record did not include documentation the paperwork was provided to the paramedics, a
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
WELLSpring HEALTH & REHABILITATION OF CASCADIA

STREET ADDRESS, CITY, STATE, ZIP CODE
2105 12TH AVENUE ROAD
Nampa, ID 83686

STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 622 Continued From page 7

verbal or written report was sent to the hospital staff, or the reason for admission to the hospital.

3. Resident #52 was admitted to the facility on 2/24/17, with multiple diagnoses including multiple sclerosis. She was readmitted on 11/13/18 and 1/15/19 following unplanned hospitalizations.

On 2/26/19 at 9:42 AM, Resident #52 stated she was admitted to a hospital a couple of times in the recent past.

Resident #52's MDS assessments, dated 11/9/18 and 1/11/19, documented she had unplanned discharges to a hospital both times.

A progress note, dated 11/19/18 at 3:50 AM, documented Resident #52 had multiple episodes of dark brown emesis throughout the night and was unable to tolerate anything by mouth and had an elevated temperature and blood pressure. The on-call physician was notified and ordered for Resident #52 to go to the ER for evaluation. Resident #52’s record stated the hospital was contacted and a report was given to an ER nurse.

There was no documentation clinical records or information was provided to the non-emergent transport staff or the receiving ER/hospital staff for Resident #52.

A progress note, dated 1/11/19 at 5:25 AM, documented Resident #52 had 2 episodes of dark brown emesis. The progress note documented the physician was notified. At 8:03 AM, the physician ordered Resident #52 be
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 622</td>
<td>Continued From page 8 transported to an ER.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 657</td>
<td>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There was no documentation in Resident #52's record verbal or written report was given or clinical records were provided to the ambulance crew or the receiving ER/hospital staff.

On 2/27/19 at 10:34 AM, UM #1 said when a resident was sent to an ER or hospital, the staff sent the resident's face sheet, medication list, H&P, code status, and the order to transport, and a nurse called and gave report to the ER/hospital staff. UM #1 said Resident #52 was hospitalized on 11/9/18 and 1/11/19 for gastrointestinal bleeding. UM #1 said she did not find documentation a verbal or written report was given to the ambulance crew or the ER/hospital staff on 1/11/19 and she did not find documentation clinical information/records were provided to the ambulance crew or ER/hospital staff when Resident #52 went to an ER on 11/9/18 and 1/11/19.

F 657 4/5/19

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
### Statement of Deficiencies and Plan of Correction

**WellSpring Health & Rehabilitation of Cascadia**

<table>
<thead>
<tr>
<th>Event ID</th>
<th>Facility ID</th>
<th>Name of Provider or Supplier</th>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Form Approved</th>
<th>OMB No.</th>
<th>Form CMS-2567(02-99) Previous Versions Obsolete</th>
</tr>
</thead>
<tbody>
<tr>
<td>F657</td>
<td>MDS001260</td>
<td>2105 12TH AVENUE ROAD</td>
<td>WELLSPRING HEALTH &amp; REHABILITATION OF CASCA</td>
<td>135094</td>
<td>03/01/19</td>
<td>If continuation sheet Page 10 of 31</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

**ID**

<table>
<thead>
<tr>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Continued From page 9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on staff interview, record review, policy review, and review of facility/dialysis provider agreement, it was determined the facility failed to ensure care plans were reviewed and revised after each comprehensive assessment and as needed by an interdisciplinary team for 1 of 2 residents (Resident #38) reviewed for dialysis services. The failure created the potential for harm if care and services were not provided to a resident as needed. Findings include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facility's care plan policy, dated 11/28/17, documented each resident's person-centered, comprehensive care plan would be reviewed and revised by an interdisciplinary team &quot;composed of individuals who have knowledge of the resident and their needs,&quot; including the resident, their representative, the physician or designee, facility staff, and &quot;Other appropriate staff as determined by the resident's needs...&quot; Further, it documented care plans are reviewed &quot;after each assessment except discharge assessments, and...&quot;</td>
</tr>
</tbody>
</table>

**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F657</td>
<td></td>
<td></td>
<td>Resident Specific</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Resident #38's care plan was reviewed by clinical management team and care plan was updated to maintain consistency and accuracy with dialysis treatments/orders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other Residents</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Residents receiving dialysis had care plans reviewed by clinical management team validate care plans accurately reflect care and services for dialysis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Facility Systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Licensed nurses were educated by Director of Nurses or designee regarding facility coordination with Dialysis validate resident care plans are updated for dialysis treatments/orders. The system is amended to include clinical management team in clinical meeting to review and...</td>
</tr>
</tbody>
</table>
**NAME OF PROVIDER OR SUPPLIER**
WELLSPRING HEALTH & REHABILITATION OF CASCADIA

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2105 12TH AVENUE ROAD
WALNUT, ID 83686

**ID**
135094

**DATE SURVEY COMPLETED**
03/01/2019

---

**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 657</td>
<td>Continued From page 10</td>
<td>revised based on changing goals, preferences and needs of the resident and in response to current interventions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The facility's dialysis policy, dated 11/2017, documented there should be development of a coordinated plan for dialysis treatments with input from both the nursing facility and dialysis provider.

The facility/dialysis provider agreement, effective 5/7/18, documented mutual obligations included documented evidence of the collaboration of care and communication between the facility and dialysis provider. The agreement also stated the documentation shall include participation by members of an interdisciplinary team, in care conferences, with signatures of team members from both parties on short and long-term care plans.

Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD requiring dialysis and CHF (heart failure).

Resident #38's quarterly MDS assessment, dated 1/14/19, documented her cognition was intact and she was on dialysis.

A nursing progress note, dated 1/21/19 at 4:10 PM, documented Resident #38 returned to the facility after placement of a hemodialysis access device to her right upper arm and the vascular catheter in her right chest was still present.

Resident #38's care plan for dialysis included the right upper chest port for dialysis and to monitor her BP before and after dialysis. There was no update of care plan for dialysis residents after appointments, consultations, and or physician directives.

Monitor
The Director of Nurses or designee will audit residents receiving dialysis care plans weekly x 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

Date of Compliance
4/5/2019
F 657 Continued From page 11

documentation she had a device in her right arm.

On 2/26/19 at 2:43 PM, LPN #1 said Resident #38 went to dialysis on Monday, Wednesday, and Friday. LPN #1 said Resident #38 had 3 dialysis access devices, one in her left upper arm that was not functional, a vascular catheter (a surgically inserted central venous catheter) in her right chest that was giving out, and the newest site was in her right upper arm.

On 2/27/19 at 1:47 PM, RN #1 said the facility staff checked Resident #38's BP in her legs, not her arms, because she had a dialysis access device in each arm. RN #1 said Resident #38's care plan did not document the presence of the new access device in her right upper arm, the non-functioning access device in her left arm, or to check her BP in her legs, not her arms.

On 2/28/19 at 2:04 PM, UM #1 said Resident #38's care plan should have been revised when the right upper arm dialysis access device was placed on 1/21/19. She said the care plan also should have been revised when it became necessary to check her BP in her lower extremities, not her arms.

F 684

SS=D

Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered
Continued From page 12

care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:

Based on staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were provided for 2 of 16 residents (#38 and #45) whose medications were reviewed. The failure created the potential for harm when medication was not administered as ordered and was not monitored for potential adverse side effects. Findings include:

1. Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD and chronic CHF.

Resident #38’s care plan documented she had impaired cardiac function related to CHF and a history of high and low BP. Interventions included monitoring her BP twice daily, before and after dialysis sessions, and to administer medications as ordered, which were initiated 12/17/18.

Resident #38’s physician orders included Clonidine (high BP medication) 0.2 mg by mouth 2 times a day PRN if her systolic blood pressure (SBP, the top number on a BP reading) was greater than 160, ordered 11/21/18, and to check her BP 2 times per day and provide Clonidine as ordered PRN, ordered 11/29/18.

Resident #38’s record documented her SBP was greater than 160 on 13 occasions in February 2019. Clonidine was not administered as ordered on 9 out of 13 times for an SBP greater than 160. The Clonidine was not administered when Resident #38's SBP was 179 on 2/6/19, 162 on 2/11/19, 173 on 2/14/19, 162 on 2/16/19, 162 on 2/18/19, and 162 on 2/20/19.

F684 Resident Specific

Education provided to nurses who provided medication administration for residents #38 and 45 to ensure understanding of medication administration policy to include but not limited to blood pressure medications administered based on parameters and anticoagulant therapy side effects monitoring. No adverse reactions are observed for these residents.

Resident #38’s physician has been notified regarding the medication provided outside of parameters. No additional directives were provided.

Other Residents

The clinical management team reviewed medication administration through random medication pass audits and blood pressure parameter reports completed on or before April 5, 2019 by Director of Nurses or designee. Adjustments have been made as indicated.

F684 Facility Systems

Licensed nurses are educated by the Director of Nursing or designee regarding medication administration to include but not limited to blood pressure medications administered based on parameters and anticoagulant therapy side effects monitoring.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135094

**DATE SURVEY COMPLETED:** 03/01/2019

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 684</td>
<td></td>
<td>Continued From page 13</td>
<td>F 684</td>
<td></td>
<td>Monitor</td>
</tr>
</tbody>
</table>

2/8/19, 173 on 2/10/19, 179 on 2/13/19, 183 on 2/15/19, 163 on 2/17/19, 166 on 2/18/19, 172 on 2/19/19, and 163 on 2/24/19.

On 2/28/19 at 2:04 PM, UM #1 reviewed Resident #38’s record and said the Clonidine was not administered as ordered when her SBP was greater than 160.

2. Resident #45 was admitted to the facility on 12/27/18, with multiple diagnoses including pleural effusion, dysphagia (difficulty swallowing), and a history of falling.

A physician order for Resident #45, dated 1/24/19, included the anticoagulant medication Eliquis 2.5 mg by mouth 2 times a day to help prevent blood clots. There were no orders to monitor him for signs and symptoms of adverse reactions, such as easy or excessive bruising, bleeding from the gums or in the urine, or internal or uncontrolled bleeding.

Resident #45’s care plan did not include or address the use of the anticoagulant medication and there was no documentation in his record he was monitored for potential adverse reactions while he was taking the Eliquis.

02/28/19 03:20 PM, UM #1 said there was no order or care plan to monitor Resident #45 for signs and symptoms of potential adverse reactions related to the use of Eliquis.

**Date of Compliance:** 4/5/2019

### CFR(s): 483.25(l) Dialysis

- **§483.25(l) Dialysis.**
  - The facility must ensure that residents who...
### NAME OF PROVIDER OR SUPPLIER

WELLSPRING HEALTH & REHABILITATION OF CASCADIA

### STREET ADDRESS, CITY, STATE, ZIP CODE

2105 12TH AVENUE ROAD  
NAMPA, ID 83686

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>

**F 698** Continued From page 14

require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:

Based on staff interview, record review, policy review, and review of the facility/dialysis provider agreement, it was determined the facility failed to ensure there was consistent collaboration and coordination of care and services between the facility and the dialysis provider. This was true for 1 of 2 residents (Resident #38) reviewed for dialysis services. The failure created the potential for harm if undetected complications went untreated or there was a delay in treatment because of lack of communication and coordination. Findings include:

The facility's dialysis policy, dated 11/2017, documented there would be coordination and collaboration between the nursing facility and dialysis provider, including the development of a coordinated plan for dialysis treatments with input from both the nursing facility and dialysis provider.

The facility/dialysis provider agreement, effective 5/7/18, documented mutual obligations included collaboration of care with both parties and documented evidence of the collaboration and communication between the facility and dialysis provider. The documentation included participation in care conferences with signatures of team members from both parties.

Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD require dialysis receive such services, consistent
with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

**F 698**

Resident Specific

Resident #38 participated in care conference with facility care team and dialysis care team on or before April 5, 2019. Documentation is reflected in the clinical record.

Other Residents

The clinical management team reviewed additional dialysis patients and provided care conferences between patients, facility care team and dialysis care team on or before April 5, 2019. Adjustments have been made as indicated.

**Facility Systems**

Social service manager and licensed nurses were educated by the Director of Nursing to coordination care conference quarterly or with change of condition, dialysis provider information is reflected on the care plan, clear documentation of mediation sent with resident to dialysis and whether resident had medication administered, hemodialysis communication is completed by facility staff, documentation in the clinical record reflects follow-up with dialysis facility when communication is not received post dialysis session. The system is amended.
**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 698</td>
<td>Continued From page 15</td>
<td>requiring dialysis and CHF.</td>
<td>Monitor</td>
<td>The Director of Nursing or designee will audit dialysis patients for coordinated plan of care for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</td>
</tr>
<tr>
<td>Monitor</td>
<td></td>
<td></td>
<td>Date of Compliance</td>
<td>4/5/2019</td>
</tr>
</tbody>
</table>
Summary Statement of Deficiencies

F 698
Continued From page 16

sometimes. UM #1 said the dialysis center staff did not attend or participate in care conferences. She said the Social Services Manager (SSM) scheduled and recorded all care conferences.

On 3/1/19 at 8:30 AM, the SSM said Resident #38's last care conference was on 6/19/18. She said she did not realize it was that long since a care conference was conducted. The SSM said Resident #38's daughter participated when she was able but the dialysis staff did not participate in the care conferences.

b. Resident #38's MARs did not include clear documentation of medications sent with her to dialysis.

Resident #38's record included a physician order, dated 11/27/18, to send two Midodrine 2.5 mg tablets with her to dialysis every Monday, Wednesday, and Friday. Midodrine is a medication used to increase blood pressure.

Resident #38's MARs for January and February 2019 included areas for documenting when the Midodrine was sent to the dialysis center with her and whether it was given by the dialysis center. The MARs documented Midodrine was sent to dialysis every M-W-F morning, except on Monday 1/21/19 and Monday 2/18/19.

The MARs documented Midodrine was not given at dialysis on 1/2/19 or 1/4/19, with a "No" written under the date. The MAR documentation was unclear whether the Midodrine was given at dialysis for the other days in January 2019 and February 2019. The facility staff documented "X", "Y", "No," "RLE," and numbers in the area for
Continued From page 17

documenting whether the Midodrine was given.

The dialysis staff documented Midodrine was administered on 1/23/19, while the facility. The January 2019 MAR documented an “x” in the space for whether it was “taken” at dialysis.

On 2/27/19 at 1:47 PM, RN #1 said Resident #38 had problems with her BP and sometimes it was low when she was at dialysis. He said the facility sent 2 Midodrine 2.5 mg tablets with her to dialysis.

On 2/28/19 at 2:04 PM, UM #1 reviewed Resident #38’s January and February 2019 MARS. She said when Resident #38 returned to the facility without the Midodrine, they assumed it was given at dialysis. She said the MAR documentation was not clear whether or not the Midodrine was given at dialysis. UM #1 said staff did not know if the Midodrine was lost or misplaced. UM #1 said it was the dialysis provider's responsibility to document when they gave the Midodrine.

c. Resident #38's record included Hemodialysis Communication forms used by the facility staff and the dialysis staff for documentation pre and post dialysis. The forms included 2 sections for documenting Resident #38's status and condition by staff, and an area for staff to sign, date, and time.

The top section, for the facility staff to complete, included areas to document Resident #38's vital signs (BP, pulse, respirations, temperature), weight pre and post dialysis, the vascular access device type, appearance, and whether the graft
or fistula had bruit (a swishing sound, indicates patency) and thrill (a vibration, indicates arterial and venous blood flow and patency) were present or not. The section also included an area to document problems since the last treatment, order and/or medication changes, and questions/concerns.

The bottom section, for the dialysis staff to complete, included areas to document Resident #38's weight, BP, and temperature pre and post treatment, vascular access device type, appearance, and post treatment bleeding time. The section also included an area for documenting the plan if a permanent access was not present, medications given during dialysis, any adverse events during treatment, physician order changes, and follow-up needed.

Resident #38's Hemodialysis Communication forms were not completed by facility staff as follows:

- Facility staff did not assess her access device dressing on 1/4/19, 1/9/19, and 2/19/19.
- Facility staff did not weigh her after dialysis on 1/4/19, 2/8/19, 2/11/19, 2/13/19, 2/18/19, and 2/25/19.
- Facility staff did not document the time on 1/4/19, 1/11/19, 1/25/19, 2/8/19, 2/15/19, and 2/22/19.

Resident #38's Hemodialysis Communication forms were not completed by dialysis staff as follows:

- Dialysis staff did not assess her access device dressing on 1/4/19, 1/28/19, and 2/22/19.
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

#### F 698
- Dialysis staff did not check her post treatment weight/BP/temperature on 1/14/19.
- Dialysis staff did not document the time on 1/2/19, 1/4/19, 1/7/19, 1/11/19, 1/14/19, 1/23/19, 1/25/19, 1/28/19, 2/6/19, 2/11/19, 2/15/19, and 2/22/19.
- Dialysis staff did not assess her access device, dressing, or monitor her post treatment bleeding time on 2/15/19.

There was no documentation the Hemodialysis Communication forms for Resident #38 were returned to the dialysis provider when they were incomplete.

On 3/01/19 at 9:09 AM, UM #2 said other than Dialysis Communication sheets, there was no other documentation of coordination and communication between the facility and dialysis provider.

#### F 700
**Bedrails**

**CFR(s):** 483.25(n)(1)-(4)

- **§483.25(n) Bed Rails.**
  The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

- **§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.**

- **§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.**
<table>
<thead>
<tr>
<th>ID/PREFIX/Tag</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID/PREFIX/Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 700</td>
<td>Continued From page 20</td>
<td>F 700</td>
<td></td>
</tr>
</tbody>
</table>

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure alternatives were attempted and safety assessments were completed prior to the installation of side rails on residents' beds. This was true for 2 of 3 residents (#23 and #52) reviewed for the use of side rails. The failure created the potential for harm if residents were to become entrapped in the side rails or sustained injury related to the use of the side rails. Findings include:

1. Resident #23 was admitted to the facility on 11/22/17, with multiple diagnoses including muscular dystrophy (progressive weakening and wasting of muscle), lymphedema (swelling of subcutaneous tissues from excessive fluid), and anxiety.

Resident #23's care plan documented he required staff assistance with ADLs (activities of daily living). Interventions included a personally owned hospital bed with air mattress, 4 side rails in the raised position per his preference, and the left side rails down as he requested to accommodate his use of personal items.

Resident #23's orders included an order, dated 7/18/18, for a Hill Rom specialty bed with air...
<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 700</td>
<td></td>
<td>Continued From page 21 mattress and 4 side rails for personal security and self-repositioning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>A Bed Safety Evaluation for Resident #23, dated 12/16/18, documented two &quot;1/4&quot; side rails were used related to an air mattress on a specialty bed and his request. The evaluation documented Resident #23 knew the risks and benefits of using side rails. The evaluation did not document whether or not he was safe using the side rails or what other interventions were tried prior to the placement of the side rails.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>On 2/26/19 at 11:39 AM, Resident #23 was observed sitting up in bed with an air mattress with two &quot;1/2&quot; side rails in the raised position on his right side.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>On 2/26/19 at 12:02 PM, Resident #23 was observed sitting up in his bed with two &quot;1/2&quot; side rails on his right side in the raised position and the side rails were in the lowered position on his left side. Resident #23 said he requested the side rails because they made him feel safer and he used them to move his upper body in bed. He said he frequently kept the left side rails down.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>On 2/27/19 at 10:00 AM, UM #1 said Resident #23's specialty bed air mattress required side rails. She reviewed his record and stated it was not documented if he was assessed to determine safety with the use of the side rails.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Resident #52 was admitted to the facility on 2/24/17, with multiple diagnoses including multiple sclerosis.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resident #52's care plan documented he admissions and/or order changes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor The Director of Nursing or designee will audit new admission residents or those with change in orders to include side rails for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date of Compliance 4/5/2019</td>
<td></td>
</tr>
</tbody>
</table>
F 700 Continued From page 22

needed assistance with all ADLs. The interventions included bilateral bed mobility bars to assist with bed mobility, which was initiated on 6/27/18 and revised on 7/19/18.

Resident #52's orders included a bed with an air overlay mattress and minimal mobility bars for increased bed mobility, dated 1/14/19.

On 2/26/19 at 9:31 AM and 2/27/19 at 11:11 AM, Resident #52 was observed in bed with an air mattress in place and bilateral "½" side rails in the raised position. Both times she said she used the side rails to move herself and help when the staff repositioned her.

Bed Safety Evaluations for Resident #52, dated 11/13/18 and 1/15/19, documented the side rails were in place. The evaluations did not include documentation Resident #52 was assessed to determine if she was safe with the use of the side rails or alternatives were attempted prior to the placement of the side rails.

On 2/27/19 at 9:49 AM, UM #1 said when Resident #52 was readmitted on 11/13/18 and 1/15/19 the Bed Safety Evaluations were just continued from a previous Bed Safety Evaluation done on 6/27/18. UM #1 said none of the Bed Safety Evaluations specifically addressed or documented if she was assessed to determine her safety with the use of the side rails or alternative interventions were tried prior to the installation of the side rails. UM #1 said Resident #52's air mattress did not require side rails. The UM reviewed Resident #52's record and said she focused on the risks and benefits of the side rails but not on the safety assessment.
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 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...
F 880 Continued From page 24

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 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, and policy review, it was determined the facility failed to ensure standard infection control measures were implemented for 2 of 8 residents (#22 and #24) during observations of blood glucose (BG) checks and medication passes. The failure created potential for harm if residents

F 880

Resident Specific Education provided to nurses who provided medication administration for residents #22 and #24 to ensure understanding of facility policy on infection control to include but not limited
developed infection from cross contamination when improper hand hygiene techniques were used, a barrier was not utilized under an eye drop container cap, and a contaminated eye drop medication was returned to a medication cart for future use. Findings include:

The facility's Hand Hygiene/Handwashing policy, dated 10/1/17, documented handwashing was the "single most important procedure for preventing the spread of infection." The policy documented alcohol-based hand rub (ABHR) may be used for routine decontamination in clinical settings. The policy documented the procedures for handwashing with soap and water, and the use of ABHR as follows:

* Soap and water: wet, wash, and rinse, the hands, wrists and exposed portions of the arms, dry with paper towels, then turn off the faucets with a paper towel and discard the paper towel.

* ABHR: apply the product to the palm of one hand and rub the hands together, "covering all surfaces of hands and fingers," until the hands are dry.

1. On 2/27/19 beginning at 4:45 PM, RN #2 was observed as she prepared a glucometer, Novolog Flexpen (a pre-filled insulin injection pen), 6 oral medications, and a nasal spray for Resident #22. RN #2 took the glucometer and medications to Resident #22's room. She performed the BG check but the glucometer gave an error reading. RN #2 told Resident #22 she was not going to inject the insulin because she needed to get more supplies to re-check the BG. RN #2 administered the oral and nasal medications, to hand hygiene, eye drop administration, and management of contaminated surfaces.

Other Residents
The clinical management team reviewed infection control practices through random medication pass audits to include eye drop administration and handwashing completed on or before April 5, 2019 by Director of Nurses or designee. Adjustments have been made as indicated.

Facility Systems
Licensed nurses were educated by Director of Nursing or designee to facility infection control policy including but not limited to hand hygiene, eye drop administration and management of contaminated surfaces.

Monitor
The Director of Nursing or designee will audit 3 random medication passes for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

Date of Compliance
4/5/2019
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 26</td>
<td>then left the room with the Novolog Flexpen and nasal spray container in her bare left hand.</td>
<td>F 880</td>
<td></td>
</tr>
</tbody>
</table>

In the hallway, near Resident #22's room, RN #2 dispensed hand sanitizer onto the palm of her right hand. She rubbed the sanitizer over the top of her left hand and fingers and the base of her left hand and used the base of her left hand to spread and rub the sanitizer over her right hand and fingers. She did not rub the hand sanitizer onto the palm of her left hand or in between the fingers of either hand. RN #2 returned to the medication cart, obtained more supplies, then returned to Resident #22's room with the Novolog Flexpen and supplies for the BG measurement.

RN #2 rechecked Resident #22's BG and administered the scheduled dose of insulin. She left the room with the glucometer and Novolog Flexpen in her bare left hand. In the hallway, near Resident #22's room, RN #2 dispensed hand sanitizer onto the palm of her right hand and repeated the technique, noted above, to rub the sanitizer on her hands.

On 2/27/19 at 4:53 PM, RN #2 said she did not rub hand sanitizer on the palm of her left hand or in between her fingers either time after the BG checks and medication administrations for Resident #22.

2. The eye drop administration policy, dated 10/07, documented the administration of eye drops included safe administration. The procedure for administration included removing the eye drop container cap, taking care to avoid touching the dropper tip, and place the cap on a clean, dry surface (such as a tissue or gauze),
administer the medication, then replace the cap and return the medication to the medication cart for storage.

On 2/28/19 at 11:25 AM, LPN #2 was observed as she prepared Pilocarpine eye drops for Resident #24. In Resident #24’s room, LPN #2 removed the cap from the eye drops and placed it on the over bed table without utilizing a barrier under the cap. As LPN #2 administered the eye drops, the cap rolled off the over bed table and fell on the floor by the bed. LPN #2 picked up the cap and began putting it on the eye drop container. LPN #2 was stopped prior to replacing the contaminated cap and she was asked about the contaminated cap and eye drop container. LPN #2 said she was going to clean them. LPN #2 then went into Resident #24’s restroom, washed her hands and the eye drop container cap with soap and water. She turned off the faucet with her bare hand, then dried her hands and the cap with paper towels. At that point, she was asked about the bare hand contact with the faucet and if soap and water was sufficient to sanitize the eye drop container cap. LPN #2 said she was going to rewash her hands, which she did, using proper technique. After that, LPN #2 took the eye drop container and cap to the medication cart, wiped both of them with alcohol wipes, put the cap back on Resident #24’s eye drop container and put the container in the medication cart for future use.

On 2/28/19 at 2:30 PM, the DNS said she expected nurses to discard contaminated eye drop containers/lids. She said washing potentially contaminated containers or caps with soap and water and/or wiping them with alcohol wipes was
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>SS=D</td>
<td></td>
<td>Continued From page 28 not sufficient. She said she was going to discard Resident #24's contaminated eye drops.</td>
<td>F 880</td>
<td></td>
<td></td>
<td></td>
<td>4/5/19</td>
</tr>
<tr>
<td>F 883</td>
<td></td>
<td></td>
<td>Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that:
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that:
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the
**Benefits and Potential Side Effects of the Immunization;**

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced by:

Based on policy review, record review, and staff interview, it was determined the facility failed to ensure immunizations were offered to residents on admission. This was true of 1 of 5 residents (Resident #35) reviewed for immunizations. This failure created the potential for harm to residents should they acquire, transmit, or experience complications from influenza and pneumococcal disease. Findings include:

The facility’s Pneumococcal and Influenza vaccine policy and procedure, dated 10/31/17, directed staff to reduce the risk of infection and transmission of pneumococcal and influenza by offering the vaccines to the residents and education regarding the benefits of immunizations.
Resident #35 was admitted to the facility on 1/3/19, with multiple diagnoses including dementia, transient cerebral ischemic attack (stroke), diabetes mellitus type 2, generalized muscle weakness and dysphagia (difficulty swallowing).

Resident #35's admission MDS assessment, dated 1/10/19, documented he was cognitively intact, he did not receive the Influenza vaccine and he was not up-to-date for the Pneumococcal vaccine.

Resident #35's record did not include a consents or education for the Influenza and Pneumococcal vaccines.

On 2/27/19 at 1:30 PM, the Clinical Resource Nurse stated the facility did not have documentation related to Resident #35's immunization status. The Clinical Resource Nurse stated the immunization status should have been determined on admission.

At 2/28/19 at 9:55 AM, UM #1 stated Resident #35's immunization status was missed and she did not know why his immunization status was not completed.

On 3/1/19 at 8:30 AM, Resident #35 stated he did not remember the facility discussing his immunization status on admission.

Licensed nurses were educated by Director of Nursing or designee to immunization policy to include but not limited to checking history of immunizations, develop immunization plan based on response, and provide immunizations as indicated. The system is amended to include clinical management team to review in clinical meeting immunization records/administration for new admissions, as well as residents scheduled for care conferences.

Monitor
The Director of Nursing or designee will audit all new admissions and residents with care conferences for appropriate immunization records for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.

Date of Compliance
4/5/2019