



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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August 29, 2018

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

Provider #: 135094

Dear Ms. Mills:

On **August 10, 2018**, 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 an isolated deficiency that constitutes actual 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.) **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 **September 10, 2018**. Failure to submit an acceptable PoC by **September 10, 2018**, may result in the imposition of civil monetary penalties by **October 1, 2018**.

Debbie Mills, Administrator
August 29, 2018
Page 2 of 4

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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Civil Monetary Penalty**
- **Denial of payment for new admissions effective November 9, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 9, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009;

Debbie Mills, Administrator
August 29, 2018
Page 3 of 4

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.

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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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 **September 10, 2018**. If your request for informal dispute resolution is received after **September 10, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility from August 6, 2018 through August 10, 2018. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Jenny Walker, RN Cecilia Stockdill, RN Wendi Gonzales, RN Survey Abbreviations: BG = blood glucose CDC = Centers for Disease Control and Prevention CNA = Certified Nursing Assistant CVA = Cerebral Vascular Accident (stroke) DNR = Do Not Resuscitate DNS = Director of Nursing Services H & P = History and Physical MAR = Medication Administration Record Meds = Medications MDS = Minimum Data Set mg = milligrams mg/dl = milligrams per deciliter MRR = Medication Regimen Review Res = Resident RN = Registered Nurse SSD = Social Services Designee s/s or s/sx = signs and symptoms UM = Unit Manager	F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		9/25/18	

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

TITLE

(X6) DATE

Electronically Signed

09/10/2018

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.

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F 580	<p>Continued From page 1</p> <p>consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility</p>	F 580			

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F 580	<p>Continued From page 2</p> <p>that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure physicians and residents' representatives were notified of changes in residents' condition. This was true for 2 of 15 (#26 and #27) residents whose records were reviewed. Resident #27's physician was not notified when her blood pressure was low, and her representative was not notified when she was transferred to a hospital. The physician was not notified when Resident #26 experienced an episode of hypoglycemia. This failed practice had the potential for harm should the residents experience a decline in their condition requiring intervention or input from their representative. Findings include:</p> <p>The facility's policy and procedure for Resident Change of Condition, dated 11/28/17, documented the following:</p> <p>* "Upon recognition of a potentially life-threatening condition or significant change in status, the nurse should communicate with other health care providers to meet the needs of the resident."</p> <p>* The facility is to immediately inform the resident, confer with the physician, and notify the resident's representative when there is "a</p>	F 580	<p>This plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Wellspring Health and Rehabilitation of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for deficiency.</p> <p>Resident Specific: The clinical management team notified resident #27's MD regarding the low BP's and requested /received parameters for MD notification. As noted in the CMS-2567, the family was notified regarding transfer from dialysis to the hospital; however, it was not noted by the nurse.</p> <p>In addition, the clinical management team notified resident #26's MD regarding the low blood sugar, no additional orders were received.</p>		

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F 580	<p>Continued From page 3</p> <p>significant change in the resident's physical, mental, or psychosocial status."</p> <p>1. Resident #27 was readmitted to the facility on 7/27/18 with multiple diagnoses, including hypotension (low blood pressure) and end stage renal disease.</p> <p>a. Resident #27's cardiopulmonary care plan, revised on 11/16/17, included the following interventions: * "Monitor and observe for s/s of cardiopulmonary complications. * Monitor vital signs. * Notify the physician of any changes in status.</p> <p>Resident #27's physician orders, dated 8/3/18, documented an order for a carvedilol tablet 3.125 mg every morning and at bedtime for hypertension.</p> <p>Resident #27's July 2018 MAR documented the carvedilol 3.125 mg was administered in the evening on 7/16/18 and 7/27/18, twice a day from 7/17-7/23/18 and 7/28-7/31/18, and in the morning on 7/24/18.</p> <p>Resident #27's Weights and Vitals Summary documented the following low BP readings:</p> <p>* Blood pressure of 86/56 on 7/16/18 at 5:22 PM. * Blood pressure of 79/51 on 7/18/18 at 5:37 PM. * Blood pressure of 88/62 on 7/19/18 at 5:00 PM. * Blood pressure of 79/61 on 7/28/18 at 2:01 AM.</p> <p>There was no documentation in Resident #27's clinical record that the physician was notified of the low pressure readings.</p>	F 580	<p>Other residents: The clinical management team reviewed other residents receiving antihypertensive agents and/or who had low blood sugars over the past two weeks. Physicians were updated as to any low readings and parameters were requested/received for MD notification as indicated. Other Residents:</p> <p>Facility Systems: Licensed nurses are educated to update physicians and/or family with change in resident condition. Re-education was provided by the Director of Nursing Service and/or designee to include but not limited to, obtaining blood pressure parameters for physician notification, documenting physician notification when blood pressure or blood glucose are outside the parameters, document family notification upon transfer to the hospital. The system is amended to include review of new medication orders in clinical meeting to validate parameters are set as indicated. In addition discharged resident records will be reviewed for documentation of family notification. Adjustments will be made as indicated.</p> <p>Monitor: The Director of Nursing Services and/or designee will audit 5 resident records with antihypertensive agents and/or blood sugar checks for physician notification when outside of parameters 3 times</p>		

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F 580	<p>Continued From page 4</p> <p>On 8/8/18 2:13 PM, RN #1 said Resident #27's normal systolic (top number) blood pressure was 130-140 and her blood pressure had been "all over the map." RN #1 said he would call the physician if a resident's blood pressure was 79/61. RN #1 said if the systolic blood pressure was over 100 and pulse was above 60, he would administer the blood pressure medication, and if the systolic blood pressure was much lower than 100 he would call the physician and would not give the blood pressure medicine. RN #1 said it looked like the carvedilol was given on the days #27's blood pressure was low.</p> <p>On 8/8/18 at 2:50 PM, UM #1 said the documented blood pressure of 79/61 for Resident #27 should not have been put in the system. UM #1 said she would have taken Resident #27's blood pressure herself to find out what was going on. UM #1 said she would have notified the doctor after she assessed Resident #27's blood pressure and verified it. UM #1 said she would not have given the carvedilol until she figured it out, and it would depend on whether the carvedilol had a parameter on it (guidelines of when to notify the physician and hold the medication). UM #1 said she thought the blood pressure reading was in error. UM #1 said there were no parameters ordered with the carvedilol, and they needed to get parameters. UM #1 said if Resident # 27 had a low blood pressure, it should have been rechecked.</p> <p>On 8/9/18 at 10:09 AM, Resident #27 said she always had blood pressure problems and it got low. Resident # 27 said her blood pressure was low in the hospital, there were lots of days when</p>	F 580	<p>weekly for 4 weeks, then weekly for 8 weeks. Records of residents transferred out of the facility will be monitored for documentation that families were notified for 12 weeks. Starting the week of September 16, 2018, the review will be documented on the PI audit tool. Any concerns will immediately and be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as deems appropriate.</p>		

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F 580	<p>Continued From page 5</p> <p>her blood pressure was low, and sometimes they gave medicine to bring it back up.</p> <p>When requested to provide policies and procedures regarding vital signs parameters and blood pressure medications, the facility provided a hand-written note that documented "we use any MD (medical doctor) parameters, pharmacy recommendations, and drug handouts."</p> <p>b. Resident #27's care plan for dialysis, initiated 8/22/17, documented she went for dialysis to an outside provider 3 times a week on Monday, Wednesday, and Friday.</p> <p>A Progress Note, dated 7/23/18 at 9:06 AM, documented Resident #27 exhibited a change in condition exhibited by confusion, disorientation, elevated blood pressure, and complaints of dizziness and not feeling "right." The healthcare provider was notified and an ambulance was called but the resident refused to go to the hospital at that time.</p> <p>A Progress Note, dated 7/23/18 at 2:24 PM, documented the dialysis center called the facility and said Resident #27 was "still very confused and not oriented" during the dialysis treatment and they were going to transfer her to the hospital after the treatment that day.</p> <p>A Progress Note, dated 7/27/18 at 6:42 PM, documented Resident #27 was readmitted to the facility from the hospital.</p> <p>There was no documentation in Resident #27's clinical record that her representative was notified of her transfer to the hospital from the</p>	F 580			

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F 580	<p>Continued From page 6 dialysis center on 7/23/18.</p> <p>On 8/9/18 at 10:09 AM, Resident #27 said she was hospitalized recently due to a urinary tract infection. Resident #27 said she did not remember anything for three days after that.</p> <p>On 8/10/18 at 9:34 AM, UM #1 said she notified Resident #27's representative of the transfer to the hospital from dialysis on 7/23/18 but there was no documentation of the conversation. UM #1 said she remembered talking to Resident #27's representative but she did not document it.</p> <p>2. The facility's policy and procedure for Diabetes Mellitus, dated 10/31/17 documented the following:</p> <ul style="list-style-type: none"> * Staff were directed to notify the physician of blood glucose levels below or above the established ranges and implement new orders as appropriate. * Hypoglycemia was defined as blood sugar below 70 mg/dl. * "Monitor resident for hypoglycemia episodes (blood sugar results below 70) and notify the physician..." * Staff were directed to document blood glucose levels, the frequency measured, and notify the physician of any changes in condition and/or diagnostic results. <p>Resident #26 was readmitted to the facility on 5/27/15 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>Resident #26's current care plan documented a hypoglycemia protocol as follows: If able to take</p>	F 580			

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F 580	<p>Continued From page 7</p> <p>orally, give 15 grams of fast acting carbohydrate and recheck BG in 15 minutes. If no improvement, notify the physician for further orders. If the condition is improving but BG is not above 70, give a second fast acting carbohydrate. May repeat in 15 minutes if BG remains less than 70 mg/dl.</p> <p>Resident #26's physician orders, dated 8/3/18, documented the following:</p> <ul style="list-style-type: none"> * Hypoglycemia protocol as previously defined in the care plan. * BG checks before meals and at bedtime, and as needed for signs/symptoms of hypo (low) or hyperglycemia (high blood sugar). * Novolog (insulin) 100 units/ml inject 16 units three times a day. <p>Resident #26's Weights and Vitals Summary documented a BG result of 64 mg/dl on 8/1/18 at 3:45 PM. The next documented BG check was 127 mg/dl at 10:45 PM on 8/1/18.</p> <p>Resident #26's MAR documented the Novolog 100 units/ml 16 units were injected at 8:00 AM, 12:00 PM, and 5:30 PM on 8/1/18. There was no documentation the hypoglycemia protocol was administered.</p> <p>There was no documentation in Resident #26's clinical record the physician was notified of the BG result of 64 on 8/1/18.</p> <p>On 8/9/18 at 10:51 AM, RN #1 said there was a diabetic protocol. RN #1 said if a resident's BG was 64, staff should give Glucagon or orange juice and recheck the BG in 15 minutes. RN #1</p>	F 580			

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F 580	Continued From page 8 said if the BG did not come up then he would call the doctor. RN #1 said the diabetic protocol defined hypoglycemia as BG less than 70. On 8/9/18 at 11:08 AM, UM #1 said her expectation was for staff to follow the hypoglycemia protocol, and she did not see charting that the hypoglycemia protocol was followed for Resident #26. UM #1 said they physician reviewed Resident #26's chart on 8/3/18 so she knew about it then. UM #1 said she had no answer for why there was no documentation of the hypoglycemia protocol being followed and the physician being notified.	F 580			
F 623 SS=G	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		9/25/18	

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 623	<p>Continued From page 9</p> <p>made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related</p>	F 623			

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F 623	<p>Continued From page 10</p> <p>disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents were given at least 30 days notice before discharge. This was true for 1 of 2</p>	F 623	<p>Resident Specific: As noted in the CMS-2567, resident #100 was discharged by her son.</p>		

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F 623	<p>Continued From page 11</p> <p>residents (#100) reviewed for discharge from the facility. The failure to provide adequate notice resulted in harm when Resident #100 required transfer from an acute care setting to a Skilled Nursing Facility (SNF) in another state where she did not have family. Findings include:</p> <p>Resident #100 was originally admitted to the facility on 9/26/17. She was readmitted on 2/19/18 with multiple diagnoses including acute and chronic respiratory failure with hypoxia (condition or state in which the supply of oxygen is insufficient for normal life functions), bacterial pneumonia, diabetes mellitus due to underlying condition with diabetic chronic kidney disease. She also had a history of acute and chronic pain, dysphagia (difficulty swallowing), and cognitive communication deficit.</p> <p>A 3/1/18 quarterly MDS assessment documented Resident #100:</p> <ul style="list-style-type: none"> * had adequate hearing * could see large print * did not speak but usually understood others and was usually understood by others * was totally dependent on staff for all activities of daily living * had limited range of motion in both upper and lower extremities * indicators of pain, such as bracing, guarding, rubbing or massaging a body part or area, clutching or holding a body part during movement, were observed daily in the last 5 days * she received 51% or more of total calories and 501 cc (cubic centimeters) per day or more of fluid intake by IV (intravenous) or tube feeding during the last 7 days 	F 623	<p>Other Residents: The ID team reviewed other residents for facility-initiated discharges without 30-day notice. No residents were identified.</p> <p>Facility Systems: The administration and Director of Nursing Services are educated by the Director of Operations regarding facility-indicated discharges and resident-initiated discharges to include but not limited to, 30-days notice provided in writing for facility-initiated discharges, chart documentation validates when resident intent is to leave the facility and return is not anticipated for resident-initiated discharges. The system is amended to include notification of the Director or Operations for any intended facility-initiated discharge prior to sending a letter or discharge. Administrator will review documentation for residents intending discharge with return not anticipated.</p> <p>Monitor: The Director of Operations and/or designee will audit resident records with facility-initiated discharges as they arise for appropriate timely and written notice weekly for 12 weeks. Starting the week of September 16, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately an discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as deemed appropriate.</p>		

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F 623	<p>Continued From page 12</p> <ul style="list-style-type: none"> * Was administered antianxiety medication 3 of the last 7 days * Insulin injections and opioid medications were administered 7 of the last 7 days * Received suctioning, tracheostomy care, and was on a ventilator during the last 14 days * Participated in the assessment. <p>A 3/7/18 MDS assessment, coded 99 as the type of assessment (which meant it was not a federally required assessment), documented Resident #100 was discharged to an acute hospital setting on 3/7/18. The MDS assessment was documented as complete on 3/15/18.</p> <p>Resident #100's care plans, goals, and interventions, included:</p> <ul style="list-style-type: none"> * Diabetes with a goal of no complications through 3/14/18, interventions included medications as ordered and BG (blood glucose) as ordered. * Cognitive deficit with memory, judgment, decision making and thought process, with a goal of Resident #100 displaying understanding by appropriately moving eyes/head in response to questions through 3/14/18. Interventions included, break activities into manageable subtasks, one instruction at a time, encourage resident to make choices within abilities, explain each activity/care prior to beginning it, gently redirect when resident makes inappropriate actions, give two choices when presenting decisions, and observe and report changes in cognitive status. * Impaired communication with a goal of 	F 623			

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F 623	<p>Continued From page 13</p> <p>Resident #100's communication needs being met as evidenced by written or non-verbal interactions by 3/14/18. Interventions included providing reassurance, patience, and pen and paper when communicating with Resident #100.</p> <p>* Risk for dehydration with a goal no signs or symptoms of dehydration through 3/14/18. Interventions included a Registered Dietician (RD) to monitor for hydration monthly and as needed and monitor for signs and symptoms of dehydration (sunken eyes, dry mucous membranes, lethargy, mental changes, decreased urinary output, dark concentrated urine, tenting skin). The interventions were initiated or revised on 10/23/17. Free water as ordered, was added 2/19/18.</p> <p>* Feeding tube required related to swallowing impairment with a goal of Resident #100 tolerating enteral feeding without complications and no significant weight loss by 3/14/18. Interventions included NPO (nothing by mouth) and NAR (nutrition at risk) review, initiated 10/3/17. Flush tube with water before and after medication administration, and lung sounds every shift and prn, both initiated 10/23/17.</p> <p>* At risk for pain related to chronic abdominal pain from "advanced endometrial cancer," revised 10/23/17, with a goal of no complaints of pain, facial grimacing or other signs and symptoms of pain by 3/14/18. Interventions included offer nonpharmacological interventions (repositioning, relaxation, backrub, or diversion), administer ordered pain medications and monitor for effectiveness, notify the physician if satisfactory relief not achieved with medication</p>	F 623			

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F 623	<p>Continued From page 14</p> <p>and other pain management techniques, assess pain every shift and as needed and rule out other causes of discomfort such as the need for repositioning and fever.</p> <p>* Inadequate/compromised respiratory function, tracheostomy, and ventilator dependence with a goal of no s/sx of respiratory distress through 3/14/18. Interventions included Respiratory Therapy (RT), ventilator settings, oxygen use, suctioning, and tracheostomy care per physician orders; head of bed elevated for comfort and to promote adequate air exchange; monitor for complications (sputum, elevated temperature, SOB (shortness of breath), "increased respiratory distress"), monitor, observe for, and report respiratory distress to physician.</p> <p>* Discharge Status, long-term care "due to my care needs being grater [sic] than can be manage [sic] by my family in the community" was initiated 3/6/18, with a goal that Resident #100 remain comfortable with her medical status and placement through 3/20/18. Interventions initiated 3/6/18 included the activities program to provide 1 to 1 visits, encourage visits from family and friends, social services to build rapport through 1 to 1 supportive visits.</p> <p>Resident #100's facility and hospital records included the following information from 2/19/18 to 3/21/18:</p> <p>* 2/19/18 at 11:25 AM Nurse's Note - Re-admission Note: Resident arrived alone, alert and "cooperative."</p> <p>* 2/19/18 at 10:30 PM Nurse's Notes - Resident</p>	F 623			

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F 623	<p>Continued From page 15</p> <p>nodding head "yes & no." Incontinent of loose stool 1 time.</p> <p>* 2/20/18 at 2:30 AM Nurse's Notes - At midnight, attempted to check BG, resident pulled hand away and placed it under blanket.</p> <p>* A 2/22/18 Nutrition Assessment documented Resident #100 returned to the facility after "possible" ventilator associated pneumonia, she was on antibiotics and probiotics, and had diarrhea. The RD documented the resident's tube feeding was changed from Glucerna to Jevity 1.2 to help with the diarrhea then changed back to Glucerna 1.5 at 75 ml/hr for 20 hours per day with 200 ml of free water every 6 hours.</p> <p>* 2/22/18 at 6:00 PM Nurse's Notes - "Dietician order to [decrease] TF [tube feeding] to 60 ml/hr. POA [power of attorney] refusing, wants it to remain at 75 ml/hr..."</p> <p>* 2/23/18 at 7:30 AM Nurse's Notes - Resident voiding "quite regular" after urinary catheter taken out. Refused BG this AM.</p> <p>* 2/25/18 at 5:30 AM Nurse's Notes - Refused BG at 6:00 AM, cooperates "when she decides."</p> <p>* 2/26/18 at 6:00 AM Nurse's Notes - 5 BMs (bowel movements) in 24 hours and 4 on 2/24/18. New order to check stool for C-diff (Clostridium difficile, a bacterium that causes diarrhea and more serious intestinal conditions such as colitis).</p> <p>* 2/26/18 at 6:00 PM Nurse's Notes - Negative C-diff, Physician Assistant notified and made</p>	F 623			

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F 623	<p>Continued From page 16</p> <p>medication changes, increased Probiotic to 3 times a day. RD (Registered Dietician) to evaluate TF formula.</p> <p>* 2/27/18 at 10:00 AM Nurse's Notes - Loose stools continue. Resident alert, nodded "no" when asked if she was in pain. No s/sx of SOB.</p> <p>* 2/27/18 at 2:00 PM Nurse's Notes - New order for Jevity 1.5 at 70 ml/hr for 20 hours, 250 cc water bolus 4 times a day, and loperamide for loose stools.</p> <p>* 3/1/18 at 10:00 PM Nurse's Notes - Before 4:00 PM, resident's daughter interrupted nurse, who was on phone with pharmacy, and said the resident's pain was 7 out of 10 and she needed an oxycodone. The nurse explained that oxycodone was not ordered but tramadol was and would be given as soon as possible. At 4:00 PM, the daughter approached the nurse, who was with another resident, and demanded the tramadol now. Tramadol was administered at 4:40 PM.</p> <p>* 3/2/18 Nurse's Notes - "Late entry for 3/1/18 - Lengthy conversation [with] resident's son & daughter regarding oxycodone." New order obtained to resume oxycodone. Son requested a decrease in oxycodone to 2.5 mg every 6 hours prn. "...discussed [with] both the facility's policy of not FaceTiming facility staff on social media platforms & to be respectful of staff's time & when asking them to stop cares by asking multiple repeated questions. Finally, I have requested family to keep clinical questions directed towards licensed nurses or RT." The entry was signed by UM #2.</p>	F 623			

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F 623	<p>Continued From page 17</p> <p>* 3/2/18 - PAR (Patient At Risk) Note: "Persistent diarrhea/New RD recommendations/Family issues continue. Diarrhea continues. On 2/22 RD attempted to [decrease] Glucerna rate in attempt to [decrease] episodes of watery stools. However, POA would not agree...Res[ident] seen again on 2/28/18 by RD...order for Jevity 1.5 at 70 ml x 20 [hours] + 250 ml QID [4 times/day]...accepted by POA...implemented [with] good results. C-diff x 2 have been negative. Will cont[inue] to follow." The entry was signed by UM #2.</p> <p>* 3/2/18 at 1:20 PM - Daughter approached nurse for pain med for resident's pain at 7 out of 10. The nurse reported "he asked res ([with] daughter present) if she was in pain. Res reported, 'No' by shake of head. When asked if she wants a pain pill again res responded [with] 'no.' Daughter recognizes [and] acknowledged resident's wishes. No meds given." The entry was signed the UM #2.</p> <p>* 3/2/18 "PM" Nurse's Notes - Resident's daughter asked oxycodone to be given more often. Resident's son called "many times" asking for CBC (complete blood count, a lab blood test) to be run, "question will be addressed to the Dr / on Dr's journal if it is necessary."</p> <p>* 3/3/18 "AM" Nurse's Notes - Resident in bed resting throughout day. Alert, respirations even, unlabored, no SOB. No complaints of pain or discomfort. Daughter visited and requested resident get oxycodone at 3:00 PM.</p> <p>* 3/5/18 at 7:00 AM Nurse's Notes - Resident in</p>	F 623			

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F 623	<p>Continued From page 18</p> <p>bed with eyes closed for a while, then "stripping, pulling at trach, refuses to wear Prevalon boots or have drsg ings [dressings] to...feet. Res given prn anxiety med [with] good results."</p> <p>* 3/6/18 at 2:10 PM Nurse's Notes - "[Physician's name] called to order indefinite hold on Lantus which he reports [POA's name] is insisting on."</p> <p>* 3/6/18 at 4:15 PM Nurse's Notes - "VSS [vital signs stable] [POA's name] repeatedly calling...insisting res be sent to hospital d/t [due to] failure. RT & RN assessed res who had already been assess by RN as easily aroused & no TF issues. Res opens eyes...skin warm & dry, resp[irations] on vent [illegible], some crackles [illegible]. BS x 4 [Bowel sounds in all 4 quadrants]. No s/s pain. Report to manager who [illegible] to [POA's name]. Res waved "goodbye" to nurse."</p> <p>* 3/7/18 at 1:04 PM Nurse's Notes - Daughter came and said the resident was in pain. The resident was assessed and "clearly nodded her head "no" when asked if she was in pain. The daughter said she saw the resident say no.</p> <p>* Resident #100's Vital Signs (VS) Flow Sheet documented her blood pressure, pulse, respirations, temperature, and oxygen saturation levels were stable on 3/6/18 and 3/17/18.</p> <p>* Daily Respiratory Therapy notes for 3/1/18 to 3/7/18 documented Resident #100's respiratory status was stable and unchanged, she was suctioned 4 times on 3/1/18 and 3/2/18, twice on 3/3/18, and once daily on 3/4/18 through 3/7/18.</p>	F 623			

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F 623	<p>Continued From page 19</p> <p>* 3/7/18 at 7:45 PM Nurse's Notes - UM #2 received a "courtesy call" from the Police Department at approximately 7:15 PM and was informed the resident's POA reported the facility was not properly caring for the resident and had requested paramedics transport the resident to a hospital ED [emergency department]. The UM "advised dispatch that the Ombudsman's office has been notified by facility management team today of the family's escalation of refusing us to provide cares to the resident, causing significantly elevated BGs (329) as well as insisting we give the resident pain medications when the resident is refusing same." Two ambulance services arrived, one at approximately 7:25 PM and another 5 minutes later. The resident's status and "family history" was provided to both ambulance services. The floor nurse gave clinical report to the first ambulance service, which included VS within normal limits, no tremors, and no s/sx of pain or discomfort. The ambulance service was informed the "transfer was at the request of the family, not because of any clinical abnormalities." The resident was transferred at 7:45 PM to the ED. The DNS, Administrator, and Medical Director were informed.</p> <p>* A 3/7/18 hospital H & P documented, "Allegedly son is not happy with the care at [name of SNF] and was told that the easiest way to deal with this was to discharge her directly to the hospital, which apparently was done. No other details of the events of the day are present. We have care [sic] for this patient previously, and she is obviously altered..." Physical Examination documented, "...She does open her eyes to mild tactile stimulus and loud voice. She does track</p>	F 623			

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F 623	<p>Continued From page 20</p> <p>from side-to-side...able to squeeze my hands, but globally weak...able to wiggle her toes, cannot bend her knees or elevate her legs...has tracheostomy, midline, well healed. Assessment and Plan was, "1. Altered mental status, likely multifactorial, no clear source of infection." Chest x-rays did not show consolidation, urine showed "no source of infection," "no obvious skin infection," and it was "unclear" if she had been having diarrhea or not. A liter of IV fluids and neurological checks every 4 hours were ordered, and fentanyl (an opioid pain medication) and vistaryl (antihistamine medication) were held. "2. Volume depletion with hyperkalemia, hypernatremia [elevated potassium and sodium levels]...chronic in nature...suspect this is secondary to lack of access to free water. She has been getting 250 cc [4 times a day] per the MAR... 3. Chronic respiratory failure... 4. Diabetes, blood sugars look high...may also be contributing to free water loss with osmotic diuresis... 5. Chronic anemia... 6. Allegedly son does not want his mother to go back to [name of facility]. He had her discharged from there today, but did decline to come into the Emergency Department...get Social Work and Case Management involved tomorrow..."</p> <p>* A 3/8/18 hospital Consultation note documented, "Impression and Plan: ...calcium and sodium are elevated because of profound dehydration...our strategy is just to be able to give her fluid and to control her electrolytes...Overall, the patient is at moderate risk for complications during her hospital stay, which includes worsening altered mental status, further electrolyte abnormalities and worsening renal failure.</p>	F 623			

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

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F 623	<p>Continued From page 21</p> <p>* On 8/10/18 at 11:00 AM, a Notice of Discharge addressed to Resident #100 son, dated 3/13/18, was provided by the facility. It was "formal notification" of the facility's intention to discharge Resident #100 "due to nonpayment of rendered charges after reasonable and appropriate notice" was given. It documented the account was past due as of 2/10/18 and the outstanding balance would need to be paid by 4/12/18 to prevent discharge. Information regarding the right to appeal was included in the notice.</p> <p>* A hospital Case Management (CM) Progress Note, dated 3/19/18 at 9:58 AM, documented transfer back to the facility was scheduled for 11:00 AM that morning and Resident #100's son agreed with the plan. At 2:08 PM, the CM documented the facility canceled the transfer "due to concerns raised by son" and the facility was working with the State Ombudsman and son "to develop acceptable boundaries for readmission to facility." The CM documented a physician contacted her "after son contacted him with financial questions and other concerns.," The CM contacted the facility and was told the financial questions were related to monies owed to the facility. The CM documented, "will hold off contacting son until situation with facility has resolved."</p> <p>A 3/19/18 physician Progress Note documented, "Chief Complaint: Altered mental status, presumed to be secondary to dehydration and question catheter-related urinary tract infection...Disposition: Awaiting for placement since it appears that the family no longer wants her to go back to [facility's name]."</p>	F 623			

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F 623	<p>Continued From page 22</p> <p>* On 8/10/18 at 4:30 PM, the SSD provided an untitled typed document, dated 3/19/18, which listed the Administrator, RTS, previous DNS, UM #2, and the SSD in attendance on a phone call with Resident #100's son, the facility's Ombudsman, and the State Ombudsman, to discuss the parameters "the facility would like to put into place before we accept the resident back." The parameters were: one phone call at 2:45 PM daily with the UM or RTS, no FaceTime when anyone else was in the room, room move near the nurse's station, must pay share of cost prior to admit, cannot drive her care - will abide by doctor's orders, and POA paperwork by close of business on 3/19/18.</p> <p>The 3/19/18 untitled document documented the son "argued" on all counts, he was "not willing to listen," he would say he would abide by the parameters then argue as to why he could not, and it was decided the Ombudsman would come to the facility for a second meeting. It documented there was a second meeting (date not provided) with the same people present except Resident #100's son who participated by phone. It documented the son "became very aggressive and argumentative," he was not willing to agree with the parameters and "had a tendency to go in circles and rehash the same information over and over." It also documented quotes from Resident #100's son included, "Bad review" with facilities in two other towns (including one in another state), "We are wonderful. We have extended his mom's life" and "More than happy to get us paid and they will get us POA paperwork."</p>	F 623			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	<p>Continued From page 23</p> <p>* A hospital CM Progress Note, dated 3/20/18 at 1:12 PM, documented the CM was notified the that "facility will not be accepting pt [patient] back." The CM "talked to son...discussed need to locate another SNF that accepts Trach/Vent patients. [Son's name] verbalized understanding." The son was informed the CM was "looking" at facilities in [name of another state]..." At 1:49 PM, the CM documented the resident's son requested she "slow down" her search for another facility "so that he could continue to work with [facility's name]." The CM documented she informed the son she would continue to search per protocol and notify him when a facility was located and she would keep him informed of any progress. At 1:59 PM, the CM documented she left a message and sent an email to a SNF in another state.</p> <p>* A 3/21/18 physician Progress Note documented, "Awaiting for placement."</p> <p>* A hospital Discharge Summary with a print date/time of 3/21/18 at 6:28 PM. Resident #100 was discharged to a facility out of state.</p> <p>On 8/10/18 at 12:48 PM, UM #2 said she was present the night Resident #100's son called 911. The UM said none of the resident's family were in facility at the time and that the resident was "fine." UM #2 said the resident's vital signs were stable, she did not have fever, and she was not having respiratory or gastrointestinal issues. UM #2 said two ambulance teams responded to the 911 call and both ambulance teams were "reluctant" to take the resident to the hospital. UM #2 said after a supervisor for one of the ambulance services arrived, they decided to take</p>	F 623			

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F 623	<p>Continued From page 24</p> <p>the resident to the hospital. UM #2 said she gave a verbal report to the paramedics and sent the resident's face sheet, medication list, code status, and the H & P with the paramedics for the hospital. UM #2 said the previous DNS, and the Administrator, were the ones who determined if Resident #100 would be readmitted or not. UM #2 said Resident #100 did not return to the facility.</p> <p>On 8/10/18 at 2:15 PM, the Respiratory Therapy Supervisor (RTS) and the Social Services Designee (SSD) said Resident #100's family's discharge plan was Resident #100 would go home with the son and nephew as the caregivers. The RTS said she had "extensive conversations" with the son and nephew by phone and with the daughter in person about the need for education and training to care for Resident #100 at home. The RTS and SSD said they "tried" to get the son and nephew to come in for training on tracheostomy care, respiratory care, tube feeding and care, and her care in general, but they "never" came in, and there was no plan for the daughter to be a caregiver. The RTS said the daughter was observed feeding Resident #100 "at least twice" when the resident was NPO, after which Resident #100 was hospitalized for aspiration pneumonia in February 2018. The SSD said the son "wanted to drive the care" Resident #100 received in the facility and "he would make decisions based on FaceTime calls with his sister" when she was visiting Resident #100. The SSD said during Resident #100's March 2018 hospitalization, that she, the previous DNS, and the Administrator had phone conversations with the son and the Ombudsman about the "parameters" needed for Resident</p>	F 623			

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F 623	Continued From page 25 #100 to return to facility. The Administrator and SSD said the facility determined Resident #100 was discharged and return to the facility was not anticipated when they were notified Resident #100's son did not want her to return to the facility. The RTS and Administrator said the hospital case manager reported the son did not want Resident #100 to return to the facility initially but later changed his mind after he checked out other SNF, including one in another state. The SSD said the facility would not allow Resident #100 to return to the facility because her son would not agree to the parameters as outlined. The RTS, SSD, and Administrator said the son initiated Resident #100's discharge from the facility when he called 911 on 3/7/18 and transferred her to the hospital. The SSD said the facility was unable to meet Resident #100's needs as defined by Resident #100's son and because the son was unwilling to agree to any parameters. The RTS said the facility "could have met the resident's needs" if the son and daughter had not been driving her care "contrary" to physician orders. Resident #100, who required specialized care including mechanical ventilation, was harmed when the facility did not provide at least 30 days notice, as they wrote in their Notice of Discharge letter to her representative on 3/13/18, and she was transferred to a facility in another state where her family and support system were not available.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		9/25/18	

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F 625	<p>Continued From page 26</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure its bed-hold policy was provided to residents. This was true for 1 of 8 residents (#27) sampled for hospitalization. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p>	F 625	<p>Resident Specific: As per CMS-2567, resident #27 was readmitted to the facility on 7/27/2018</p> <p>Other Residents: The ID team reviewed other residents currently out of the facility for notification of the bed hold policy. Residents have been provided a bed-hold notification as indicated.</p>		

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F 625	<p>Continued From page 27</p> <p>The facility's policy and procedure for Transfer and Discharge, dated 11/28/17, documented the following: "At the time of transfer/discharge, the resident and a family member or legal representative are given a written notice of the bed-hold policy that specifies the duration of the bed-hold and readmission criteria after the bed-hold period ends."</p> <p>Resident #27 was readmitted to the facility on 7/27/18 with multiple diagnoses, including hypotension (low blood pressure) and end stage renal disease.</p> <p>Resident #27's Admission Agreement, from admission date 3/15/17, documented bed hold charges would be assessed "based on the daily room rate if the Resident and/or Responsible Party elect to reserve a bed during the Resident's absence from the Facility. Prior arrangements for bed holds must be made with Facility management."</p> <p>A Progress Note, dated 7/23/18 at 9:06 AM, documented Resident #27 experienced a change in condition exhibited by confusion, elevated blood pressure, and dizziness. The healthcare provider was notified and an ambulance was called. The resident refused to go to the hospital at that time.</p> <p>A Progress Note, dated 7/23/18 at 2:24 PM, documented the dialysis center called the facility and planned to transfer Resident #27 to the hospital due to her being confused during treatment on that day.</p> <p>A Progress Note, dated 7/27/18 at 6:42 PM,</p>	F 625	<p>Facility Systems: Admission Coordinator, Resident Services Coordinator, Resident Care Manager, and Director of Nursing Services are educated to the bed-hold policy by the administrator and/or designee to include but not limited to, notification of the bed-hold policy prior to transfer next business day post emergent transfer. They system is amended to include review of resident records who are out of the facility in clinical meeting for validation of bed-hold notification.</p> <p>Monitor: The Administrator and/or designee will audit records of residents who are out of the facility for validation of bed-hold policy notification weekly for 12 weeks. Starting the week of September 16, 2018 the review will be documented on the PI audit tool Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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F 625	Continued From page 28 documented Resident #27 was readmitted to the facility from the hospital. There was no documentation in Resident #27's clinical record of a bed hold policy being provided or discussed with her or her family member at the time of her transfer to the hospital from the dialysis center on 7/23/18. On 8/9/18 at 10:09 AM, Resident #27 said she was hospitalized recently due to a urinary tract infection. Resident #27 said she did not remember anything for three days after that. On 8/9/18 at 10:40 AM, UM #1 said it was not the facility's practice to provide residents with a bed hold policy and she had never seen it used.	F 625			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		9/25/18	

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F 656	<p>Continued From page 29</p> <p>under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' comprehensive care plans were consistent with physician orders and addressed residents' insomnia, anxiety, and antipsychotic medication. This was true for 3 of 15 sampled residents (#26, #34, and #49) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>The facility's policy and procedure for Care Plans, dated 11/28/17, documented the following:</p>	F 656	<p>Resident Specific:</p> <p>The ID team reviewed care plans to be consistent with physician orders as follow:</p> <p>Resident #34 - updated the diagnosis to include somatic delusions disorder, behavioral monitoring and the use of medication</p> <p>Resident #49 - updated the diagnosis to include insomnia and anxiety with use of medication.</p> <p>Resident #26 - updated to notify the physician if BG was greater than the sliding scale insulin.</p>		

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F 656	<p>Continued From page 30</p> <p>* "A comprehensive care plan is developed consistent with the resident's specific conditions, risks, needs, behaviors..."</p> <p>* The comprehensive care plan described "Services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."</p> <p>* The comprehensive care plan reflected interventions that would facilitate meeting the resident's objectives.</p> <p>* The care plan reflected current professional standards of practice.</p> <p>* The care plan was revised and updated, as needed, to reflect the resident's current status.</p> <p>This policy was not followed. Examples include:</p> <p>1. Resident #26 was readmitted to the facility on 5/27/15 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>Resident #26's current care plan directed staff to follow the insulin sliding scale or contact the physician and follow orders for hyperglycemic (BG above 300 mg/dl). The intervention was initiated on 6/23/18 and updated on 7/9/18.</p> <p>Resident #26's physician orders, dated 8/3/18, documented the following:</p> <p>* BG checks before meals and at bedtime, ordered on 5/31/18.</p> <p>* BG checks as needed for signs/symptoms of hypo (low) or hyperglycemia (high BG), ordered on 5/8/18.</p> <p>* Notify the physician if BG greater than 400, ordered on 5/8/18.</p>	F 656	<p>Other residents: The ID team reviewed other residents who receive psychotropic medications for care plans that are consistent with physician orders. Adjustments have been made as indicated.</p> <p>The ID team reviewed other residents with diagnosis of diabetes for hyperglycemia parameters that match the physician sliding scale. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses and Resident Services Coordinator are educated to person-centered care plans. Re-education was provided by the Director of Nursing Services and/or designee to include but not limited to, 48 hour care plan details, use of psychotropic medication and behavior monitors, and parameters for hyperglycemia consistent with sliding scale insulin directives.</p> <p>Monitor: The MDS nurse and/or designee will audit 5 resident care plans for medication accuracy at the 48-hour, psychoactive medication use, and diabetes parameters weekly for 4 weeks, then 3 weekly for 8 weeks. Starting the week of September 16, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI Committee may adjust the frequency of the</p>		

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(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	
F 656	Continued From page 31 Resident #26's care plan stated the physician was to be contacted if the resident's hyperglycemic BG level was above 300 mg/dl. The physician's order indicated to notify the physician if Resident #26's BG level was greater than 400. On 8/9/18 at 11:08 AM, UM #1 said Resident #26's physician order and care plan did not match and she thought it could have been because the care plan did not get updated with recent changes to the insulin orders. 2. Resident #49 was admitted to the facility on 7/12/18 with multiple diagnoses, including major depressive disorder, recurrent and severe without psychotic features, and legal blindness. Resident #49's Admission MDS assessment, dated 7/19/18, documented the following: * He was cognitively intact. * Depression was present. * Antipsychotic and antidepressant medications were received on 7 of the past 7 days. Resident #49's physician orders, dated 8/9/18, documented the following: * Alprazolam (anti-anxiety medication) tablet 0.5 mg by mouth as needed for anxiety, up to three times per day. * Duloxetine HCL (antidepressant medication) capsule Delayed Release 90 mg in the morning related to major depressive disorder. * Quetiapine Fumarate (antipsychotic medication) tablet 25 mg 0.5 tablet as needed for insomnia at	F 656	monitoring after 12 weeks, as it deems appropriate.		

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F 656	<p>Continued From page 32</p> <p>bedtime.</p> <p>* Vraylar (antipsychotic medication) capsule 6 mg in the morning related to major depressive disorder.</p> <p>* Doxepin HCL (antidepressant medication) capsule 10 mg as needed for insomnia once daily at bedtime.</p> <p>Resident #49's current care plan documented the following:</p> <p>* The resident used psychotropic medications related to depression.</p> <p>* Staff were directed to administer medications as ordered and monitor/document side effects and efficacy.</p> <p>The care plan did not address anxiety for which Resident #49 received anti-anxiety medication and insomnia for which Resident #49 received an antipsychotic medication.</p> <p>On 8/9/18 at 4:00 PM, UM #1 said insomnia and anxiety should have been on Resident #49's care plan.</p> <p>3. Resident #34 was admitted to the facility on 6/18/18. The resident's Abbreviated Level 2 PASRR (Preadmission Screening and Resident Review) Screening for Nursing Facility Placement, dated 6/14/18, documented diagnoses of severe mental illness. The diagnoses were major depressive disorder and somatic delusion. An H & P, dated 6/19/18, documented a diagnosis of depression also but did not mention somatic delusion disorder.</p> <p>Resident #34's hospital medication profile report,</p>	F 656			

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F 656	Continued From page 33 dated 6/14/18, documented three psychoactive medications were to be continued. The three psychoactive medications were Celexa (antidepressant) 10 mg daily, Wellbutrin (antidepressant) 100 mg three times daily, and Risperdal (antipsychotic) 0.25 mg twice daily. Resident #34's June 2018 Skilled Nursing Facility orders documented the same three psychoactive medications at the same dose and frequency. The Celexa and Wellbutrin were both ordered for depression and the Risperdal was ordered for somatic delusion disorder. Resident #34's June, July, and August 2018 MARs documented the Celexa, Wellbutrin, and Risperdal were administered as ordered from 6/18/18 through mid day on 8/10/18. Resident #34's Baseline Care Plan documented "Thinks she is infected [with] bugs" as a behavior concern and that medications included Risperdal and Celexa. The Baseline Care Plan did not mention the Wellbutrin. The comprehensive care plan addressed Resident #34's depression, and included goals and interventions for the depression. The comprehensive care plan did not mention the somatic delusion disorder or the use of the antipsychotic medication Risperdal. On 8/9/18 at 11:15 AM, the SSD said she had not initiated a care plan or a behavior monitoring flowsheet for Resident #34's somatic delusion disorder.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		9/25/18	

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F 684	<p>Continued From page 34</p> <p>§ 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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were maintained pertaining to diabetic management, blood pressure management, and death of a resident. This was true for 3 of 15 (#26, #27, and #52) residents whose records were reviewed.</p> <p>* Resident #26 experienced a low blood sugar, and the hypoglycemia (low blood sugar) protocol was not administered. * Resident #27 experienced low blood pressure, and blood pressure lowering medication was still administered. * Resident #52 passed away and there was no documentation regarding the circumstances at the time of death, no order to release the body, and no documentation the resident's representative and physician were notified.</p> <p>This failed practice had the potential for harm should residents experience a decline in health related to low blood sugar or low blood pressure, should there not be a determination of the circumstances surrounding the death, and should</p>	F 684	<p>Resident specific: The clinical management team reviewed professional standards of practice as follows: Resident #26 - as per CMS-2567 they physician reviewed hypoglycemia results. No additional adjustments are indicated. Resident #27 - They physician was contacted regarding low BPs and requested/received parameters for MD notification, no additional adjustments were indicated. Resident #52 - The standard of practice does not allow for alteration of the medical records, not adjustments were made post discharge.</p> <p>Other Residents: See F580 regarding review of other residents receiving antihypertensive agents and/or who had low blood sugars over the past two weeks. Physicians were updated as to low readings and parameters were requested/received for MD notification as indicated.</p>		

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F 684	<p>Continued From page 35</p> <p>the physician and resident's representative not be aware of the resident's death. Findings include:</p> <p>The facility's policy for Diabetes Mellitus, dated 10/31/17, directed staff to do the following:</p> <ul style="list-style-type: none"> * Notify the physician of blood glucose levels below or above the established ranges and implement new orders as appropriate. * "Monitor [the] resident for hypoglycemia episodes (blood sugar results below 70) and notify the physician..." * Document blood glucose levels, the frequency measured, and notifying the physician of any changes in condition and/or diagnostic results. <p>When requested to provide policies and procedures regarding vital signs parameters and blood pressure medications, the facility provided a hand-written note that documented "we use any MD (Medical Doctor) parameters, pharmacy recommendations, and drug handouts."</p> <p>The National Heart, Lung, and Blood Institute website, accessed 8/14/18, defined hypotension (low blood pressure) as blood pressure that is lower than 90/60.</p> <p>The American Diabetes Association website, accessed 8/14/18, defined hypoglycemia (low blood sugar) as blood sugar levels less than 70 mg/dl.</p> <p>1. Resident #26 was readmitted to the facility on 5/27/15 with multiple diagnoses, including Type 2 diabetes mellitus.</p>	F 684	<p>The clinical management team reviewed other residents who had expired in the past two weeks for documentation of family and physician notification. No adjustments indicated.</p> <p>Facility Systems: Licensed nurses are educated to a professional standard. Re-education was provided by the Director of Nursing Services and/or designee to include but not be limited to, implementing and documenting the hypoglycemia protocol, obtaining parameters for antihypertensive/holding the medication as indicated an documenting physician and family notification after the death of a resident. The system is amended to include review of hypoglycemia protocol and administration of antihypertensive agents within the parameter of surveillance monitoring of medication administration for licensed nurses. Residents records are reviewed post discharge in clinical meeting to validate documentation of physician and family with resident death.</p> <p>Monitor: The Director of Nursing Services and/or designee will audit 2 licensed nurses for hypoglycemia management and administration of antihypertensive agents within the parameters weekly for 4 weeks, then 1 nurse weekly for 8 weeks. In addition, resident discharge records will be reviewed for physician and family</p>		

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F 684	<p>Continued From page 36</p> <p>Resident #26's current care plan documented a hypoglycemia protocol as follows: If able to take orally, give 15 grams of fast acting carbohydrate and recheck BG in 15 minutes. If no improvement, notify the physician for further orders. If the condition is improving but BG is not above 70, give a second fast acting carbohydrate. May repeat in 15 minutes if BG remains less than 70 mg/dl.</p> <p>Resident #26's physician orders, dated 8/3/18, documented the following:</p> <ul style="list-style-type: none"> * Hypoglycemia protocol as previously defined in the care plan. * BG checks before meals and at bedtime, and as needed for signs/symptoms of hypoglycemia or hyperglycemia (high blood sugar). * Novolog (insulin) 100 units/ml inject 16 units three times a day. <p>Resident #26's Weights and Vitals Summary documented a BG result of 64 mg/dl on 8/1/18 at 3:45 PM. The next documented BG check was 127 mg/dl at 10:45 PM on 8/1/18.</p> <p>Resident #26's MAR documented Novolog 100 units/ml 16 units were injected at 8:00 AM, 12:00 PM, and 5:30 PM on 8/1/18. There was no documentation the hypoglycemia protocol was administered.</p> <p>On 8/9/18 at 10:51 AM, RN #1 said he was aware of the diabetic protocol. RN #1 said if a resident's BG was 64, staff should give Glucagon or orange juice and recheck the BG in 15 minutes. RN #1 said if the BG did not come up then he would call the doctor. RN #1 said the</p>	F 684	notification. Starting the of September 16, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks and it deems appropriate.		

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

PRINTED: 01/11/2019
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F 684	<p>Continued From page 37</p> <p>diabetic protocol defined hypoglycemia as BG less than 70.</p> <p>On 8/9/18 at 11:08 AM, UM #1 said her expectation was for staff to follow the hypoglycemia protocol, and she did not find charting that the hypoglycemia protocol was followed for Resident #26. UM #1 said the physician reviewed Resident #26's chart on 8/3/18 so she knew about it then. UM #1 said she had no answer for why there was no documentation of the hypoglycemia protocol being followed.</p> <p>2. Resident #27 was re-admitted to the facility on 7/27/18 with multiple diagnoses, including hypotension (low blood pressure).</p> <p>Resident #27's current care plan documented the following:</p> <ul style="list-style-type: none"> * Impaired cardiac function related to anemia, congestive heart failure, history of hypertension (high blood pressure), hypotension, hyperlipidemia (high cholesterol), and chronic obstructive pulmonary disease. * "Monitor and observe for s/s (signs and symptoms) of cardiopulmonary complications." * Monitor vital signs. * Notify the physician of any changes in status. <p>Resident #27's physician orders, dated 8/3/18, documented an order for carvedilol tablet 3.125 mg every morning and at bedtime for hypertension.</p> <p>Resident #27's July 2018 MAR documented the carvedilol 3.125 mg was administered in the</p>	F 684			

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F 684	<p>Continued From page 38 evening on 7/16/18 and 7/27/18, twice a day from 7/17/18 - 7/23/18 and 7/28/18 - 7/31/18, and in the morning on 7/24/18.</p> <p>Resident #27's Weights and Vitals Summary documented the following:</p> <ul style="list-style-type: none"> * Blood pressure of 86/56 on 7/16/18 at 5:22 PM. The next documented blood pressure was on 7/17/18 at 9:28 AM. * Blood pressure of 79/51 on 7/18/18 at 5:37 PM. The next documented blood pressure was on 7/19/18 at 10:50 AM. * Blood pressure of 88/62 on 7/19/18 at 5:00 PM. The next documented blood pressure was on 7/20/18 at 8:14 AM. * Blood pressure of 79/61 on 7/28/18 at 2:01 AM. The next documented blood pressure was on 8/1/18 at 3:03 AM. <p>On 8/8/18 2:13 PM, RN #1 said Resident #27's normal systolic (top number) blood pressure was 130-140 and her blood pressure had been "all over the map." RN #1 said he would call the the physician if a resident's blood pressure was 79/61. RN #1 said if the systolic blood pressure was over 100 and pulse was above 60, he would administer the blood pressure medication, and if he systolic blood pressure was much lower than 100 he would call the physician and would not give the blood pressure medicine. RN #1 said it looked like the carvedilol was given on the days #27's blood pressure was low.</p> <p>On 8/8/18 at 2:50 PM, UM #1 said the documented blood pressure of 79/61 for Resident #27 should not have been put in the system. UM #1 said she would have taken the</p>	F 684			

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F 684	<p>Continued From page 39</p> <p>blood pressure herself and find out what was going on. UM #1 said she would notify the doctor after she assessed the blood pressure and verified it. UM #1 said she would not give the carvedilol until she figured it out, and it would depend on whether the carvedilol had a parameter on it (guidelines of when to notify the physician and hold the medication). UM #1 said she thought the blood pressure numbers were an error. UM #1 said there were no parameters ordered with the carvedilol, and they needed to get parameters. UM #1 said if Resident # 27 had a low blood pressure, they should have re-checked it.</p> <p>On 8/9/18 at 10:09 AM, Resident #27 said she always had blood pressure problems. Resident # 27 said her blood pressure was low in the hospital, there were lots of days when her blood pressure was low, and sometimes they gave medicine to bring it back up.</p> <p>3. The facility's Patient Death policy, dated 3/31/18, documented notification should be made to the physician and family member or responsible party, mortician, appropriate disciplines of discharge, and funeral home. The policy further stated documentation should also include the date and time of the pronouncement of death, date and time of release of the body, and the medical record was to include documentation of relevant information regarding the death.</p> <p>Resident #52 was admitted to the facility on 1/29/18 with multiple diagnoses, including dementia, hemiplegia and hemiparesis (paralysis on one side of the body), muscle wasting and</p>	F 684			

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F 684	<p>Continued From page 40</p> <p>atrophy, history of prostate cancer, and dysphagia (difficulty swallowing).</p> <p>Resident #52's admission MDS assessment, dated 2/5/18, documented he was cognitively impaired.</p> <p>Resident #52's care plan, dated 2/22/18, documented his DNR (Do Not Resuscitate) code status and that he was cognitively impaired.</p> <p>Resident #52's family and funeral chapel contact information, no date indicated, documented upon the death of the resident, family and the funeral chapel were to be contacted.</p> <p>Resident #52's nurse progress note, dated 7/9/18, documented he was resting quietly through the night, he was repositioned, pericare provided, and barrier cream applied. The note stated Resident #52 had mottled (blotched) feet and his breathing pattern started to change toward early morning.</p> <p>Resident #52's nurse progress note, dated 7/10/18, documented he had been very lethargic, did not eat breakfast, would not take medications willingly, got up in chair for the day, but was laid down right after each meal.</p> <p>Resident #52's medical record final summary sheet, dated 7/10/18, documented he expired.</p> <p>Resident #52's Death in Facility MDS assessment, dated 7/10/18, documented he was deceased.</p> <p>Resident #52's mortician's receipt, dated 7/10/18</p>	F 684			

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F 684	Continued From page 41 at 7:40 am, documented his body was released to a funeral chapel. Resident #52's physician's note, dated 8/10/18, documented his cause of death was due to complications related to age, CVA, dementia, and history of prostate cancer, and he had profound debility and dementia leading to continued decline. On 8/10/18 at 12:42 PM, UM #1 stated Resident #52 basically just went to sleep and did not wake up. She said she thought he passed about 5:00 AM. UM #1 said there was no further documentation. On 8/10/18 at 2:24 PM, the DNS, Clinical Resource Nurse, and Senior Clinical Resource Nurse, stated that when a resident dies, it is expected that the physician, family or representative and mortuary be notified, there should be a physician's order for release of the body, and a documented nurse's progress note. The facility did not provide documentation of notification to the physician and family member or responsible party, and appropriate disciplines of discharge, a physician order for release of the body, or complete documentation regarding the death of Resident #52.	F 684			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/25/18	

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F 690	<p>Continued From page 42</p> <p>condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' urinary care needs were met. This was true for 1 of 1 residents (#5) sampled for bowel and bladder incontinence. This was true when Resident #5 smelled of urine and the cushions in her assistive chair were wet with</p>	F 690	<p>Resident specific:</p> <p>The ID team reviewed resident #5 for incontinence management. The toileting plan is updated, wheelchair cushion replace and a plan for wheelchair/pad cleaning is implemented. Round validate that the urine odor is resolved.</p>		

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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	
F 690	<p>Continued From page 43</p> <p>urine. This failure created the potential for harm should residents experience skin breakdown, urinary tract infections, and physical and emotional discomfort from remaining in soiled materials. Findings include:</p> <p>Resident #5 was admitted to the facility on 9/2/10 with multiple diagnoses, including unspecified dementia with behavioral disturbance, adult failure to thrive, and muscle weakness.</p> <p>Resident #5's quarterly MDS assessment, dated 5/11//18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Total dependence on two person physical assistance with toileting, bed mobility, and transfers. * Total dependence on one person physical assistance with personal hygiene. <p>Resident #5's current care plan documented the following:</p> <ul style="list-style-type: none"> * Staff assistance with all activities of daily living. * Hospice to provide additional bathing and incontinence supplies. * Turn side to side as the resident will allow, and reposition when making rounds and as needed using a turning sheet. * Incontinence of bowel and bladder, and requires staff to anticipate needs. Provide incontinence briefs, check and change when making rounds and as needed. <p>Resident #5's August 2018 Documentation Survey Report (documentation of CNA tasks) did not document bladder care on the day shift on</p>	F 690	<p>Other Residents: The IDT team reviewed other incontinent residents for toileting plans and urine odors. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses and CNAs are educate to incontinence management. Re-education was provided by the Director of Nursing Services an td/or designee to include but not limited to adjustment in toileting schedule, incontinent products utilized, wheelchair/cushion cleaning, and the need for a homelike environment free of urine odors. They system is amended to include surveillance of incontinence management during rounds.</p> <p>Monitor: The Director of Nursing Services and/or designee will audit incontinence manager and prevalence of urine odors on 5 residents weekly for 4 weeks, then 3 residents weekly for 8 weeks. Starting the week of September 16, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 690	<p>Continued From page 44 8/2/18 - 8/4/18 and on night shift on 8/3/18 - 8/4/18.</p> <p>On 8/7/18 at 3:34 PM, Resident #5 was asleep in her bed and a mild smell of urine was noted in her room.</p> <p>On 8/8/18 at 2:30 PM, Resident #5 was asleep in her bed and a strong urine odor was noted in her room. The wound nurse performed a skin check, including Resident #5's buttocks. The wound nurse acknowledged there was a smell of urine in the room. Upon inspection, the pressure reducing cushion on the seat of Resident #5's assistive chair appeared wet and smelled of urine. The wound nurse checked the cushions on Resident #5's chair and discovered the foam cushion that supported the resident's back was wet and appeared wet with urine. The wound nurse said they would clean the pressure reducing cushion and would have hospice replace the foam cushion behind the resident's back.</p> <p>On 8/8/18 at 2:40 PM, CNA #1 said the CNAs checked residents to see if they were wet three times a shift, when first coming on shift, before dinner, after dinner, and as needed if there was an odor.</p> <p>On 8/8/18 at 2:42 PM, CNA #2 said the CNAs checked residents for incontinence three to four times a shift.</p> <p>On 8/8/18 at 2:47 PM, UM #1 said residents should be checked every two hours for incontinence, and she did not know how it happened that Resident #5's cushions were wet in her assistive chair.</p>	F 690			

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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	
F 690	Continued From page 45 On 8/9/18 at 9:24 AM, Resident #5 was sitting in her assistive chair in her room, and a mild smell of urine was noted in her room. CNA #3 and CNA #4 transferred Resident #5 to bed from her chair, removed a soiled incontinence brief, and provided incontinence care. CNA #4 said Resident #5 was last checked and changed at 7:30 AM. On 8/9/18 at 9:44 AM, UM #1 said the hospice CNAs came to provide care to Resident #5 on Mondays and Thursdays. UM #1 said on Monday of that week the hospice CNA did not notice the foam cushion was wet in Resident #5's chair. UM #1 said the staff knew Resident #5 would be really wet after lunch, and staff needed to increase how often they checked her. UM #1 said the physician and hospice were notified of Resident #5's incontinence, and the incontinence had been large. UM #1 said staff needed to get some better incontinent coverage or get some better cushions for Resident #5. UM #1 said she needed to change the task and needed to add how often incontinence care was provided in a shift. On 8/9/18 at 9:58 AM, UM #1 said she did not have an answer for why there was no documentation of bladder care being provided on the mentioned missing areas on the August 2018 Documentation Survey Report , other than the facility started using a computer program on August 1, 2018 and "apparently some people were struggling."	F 690			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		9/25/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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	
F 756	<p>Continued From page 46</p> <p>§483.45(c) Drug Regimen Review.</p> <p>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p>	F 756			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 756	<p>Continued From page 47</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the pharmacy reported medication irregularities and recommendations were acted upon, or addressed by the attending physician. This was true for 1 of 6 sample residents (#34) whose monthly MRR were reviewed. The failure created the potential for harm when a reported irregularity regarding the use of two antidepressants was not acted upon or responded to for 45 days. Findings include:</p> <p>Resident #34 was admitted to the facility on 6/18/18 with multiple diagnoses, including depression.</p> <p>Resident #34's hospital medication profile report, dated 6/14/18, documented 2 antidepressant medications were to be continued. The antidepressants were Celexa 10 mg daily and Wellbutrin 100 mg three times daily.</p> <p>Resident #34's June 2018 facility physician orders documented the Celexa and Wellbutrin were active.</p> <p>A 6/25/18 MRR to Resident #34's physician documented, "The combined use of more than one antidepressant medication has not been demonstrated to be more effective than a single agent and has the potential for increased side effects...the use of more than one antidepressant may be viewed as duplicate (and unnecessary) therapy... Please consider either treating...with a single antidepressant or documenting...your rationale for using more than one</p>	F 756	<p>Resident Specific: As noted in the CMS-256 resident #34 pharmacy recommendations were processed by the physician as indicated.</p> <p>Other Residents: The clinical management team reviewed the last 2 months of pharmacy recommendations of other residents, the physicians were updated. Adjustments have been made as indicated.</p> <p>Facility Systems: Resident care managers were educated to process review for pharmacy recommendations. Re-education was provided by the Director of Nursing Services and/or designee to include but not limited to acting upon the pharmacy recommendations timely, validation that the physician response is timely, and processing order changes as indicated. They system is amended to include review in clinical meeting after pharmacy visit.</p> <p>Monitor: The Director of Nursing Services and/or designee will audit drug regiment reviews for completion each month for 3 months. Starting the week of September 16, 2018 the review will be documented on the pharmacy recommendation summary. Any concerns will be immediately and discussed with the PI Committee. The PI committee may a adjust the frequency of</p>		

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

PRINTED: 01/11/2019
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(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	
F 756	Continued From page 48 antidepressant..." A 7/2/18 Physician's Telephone Order increased Resident #34's Celexa to 20 mg daily and the resident's active physician orders, as of 8/9/18, included Celexa 20 mg daily and Wellbutrin 100 mg three times daily. Resident #34's MARs for June, July, and August 2018 documented the Celexa and Wellbutrin were administered as ordered from 6/18/18 through mid day on 8/10/18. On 8/10/18 at 12:57 PM, UM #2 said the facility received the MRR recommendations from the pharmacist via email. UM #2 said on 8/9/18, during the survey, she noticed Resident #34's physician had not responded to the 6/25/18 MRR recommendation to discontinue one of the antidepressants or provide a rationale why both antidepressants were necessary. UM #2 said she sent the recommendation to the physician on 8/9/18 (45 days after the 6/25/18 MRR) and received an order on 8/10/18 to decrease the Wellbutrin by 50%.	F 756	the monitoring after 12 weeks as it deems appropriate.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		9/25/18	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 758	Continued From page 49 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758			

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 758	<p>Continued From page 50</p> <p>Based on resident and staff interview, record review, and facility policy review, it was determined the facility failed to: a) Obtain the resident's consent prior to administering psychoactive medications, b) Monitor behaviors for residents receiving psychoactive medications, and c) Provide an appropriate order for a PRN (as needed) anti-anxiety medication. This was true for 3 of 6 residents (#31, #34, and #49) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents receive psychotropic medications that were unwarranted, not adequately monitored, and used for excessive duration. Findings include:</p> <p>The facility's policy and procedure for Unnecessary Medications and Psychotropic Drugs documented the following:</p> <ul style="list-style-type: none"> * "A patient's medication regimen is free of any medication used in excessive dose (including duplicate therapy), excessive duration, without adequate monitoring, without adequate indications for its use..." * The interdisciplinary team would complete a thorough resident comprehensive assessment, including each patient's goals and preferences. * The resident and/or representative would be informed about the resident's condition, treatment options, risks and benefits of treatment, and the right to refuse treatment. * The use of PRN psychotropic medications would be limited to 14 days, and a new order would not be entered without a physician's evaluation. * A PRN order may be extended beyond 14 days if the physician believed it was appropriate. The 	F 758	<p>Resident Specific:</p> <p>The IDT team reviewed unnecessary medication:</p> <p>Resident #34 - care plan was updated as in F656, a monitor is established for specific target behaviors, the physician implemented the pharmacy recommendations</p> <p>Resident #49 - was educated for risk and benefits of psychotropic medication and consent was signed, monitor is established for specific target behaviors, and PRN order was reviewed by physician and limited to 14 days.</p> <p>Resident #31 - monitor is established for specific target behaviors and entered into the electronic medical record for documentation.</p> <p>Other Residents:</p> <p>The IDT team reviewed other residents receiving psychotropic medications for consents, diagnosis updates, care plans, specific target behaviors monitored, 14 day limit for PRN use, and physician notification for multiple drug use/pharmacy recommendations. Adjustments have been made as indicated.</p> <p>Facility Systems:</p> <p>Licensed nurses and Resident Services Coordinator are educated to unnecessary medications. Re-education was provided by the Director of Nursing Services and/or designee to include but not limited to resident education, timely consent, specific target behaviors</p>		

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 758	<p>Continued From page 51</p> <p>physician would visit the resident and document the rationale for the extended use of the medication.</p> <p>* For PRN antipsychotic medications, the time would be limited to 14 days with no exception. If the physician wished to prescribe a new order for the PRN antipsychotic medication, the physician would first evaluate the resident and perform a direct examination of the resident.</p> <p>1. Resident #49 was admitted to the facility on 7/12/18 with multiple diagnoses, including major depressive disorder, recurrent, severe without psychotic features, and legal blindness.</p> <p>Resident #49's Psychoactive Medication Informed Consents, dated 7/12/18, documented a family member signed the consent forms on 7/12/18 for the use of:</p> <ul style="list-style-type: none"> * Quetiapine (antipsychotic medication) * Vraylar (antipsychotic medication) * Duloxetine (antidepressant medication) * Doxepin (antidepressant medication) * Alprazolam (anti-anxiety medication) <p>There was no documentation regarding the purpose of the medications, including the specific condition, expected beneficial effects, and possible side effects of the medications. There was no documentation whether the resident did or did not desire or consent to use of any of the psychoactive medications.</p> <p>Resident #49's Admission MDS, dated 7/19/18, documented the following:</p> <ul style="list-style-type: none"> * He was cognitively intact. 	F 758	<p>monitored, 14 day limit on PRN use, and physician notification for multiple drug use/pharmacy recommendations. The system is amended to include review of new medications and/or order changes in clinical meeting and with care conference.</p> <p>Monitor: The Director of Nursing and/or designee will audit 5 resident records for management of psychotropic medications weekly for 4 weeks, then 3 weekly for 8 weeks. Starting the week of September 16, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.</p>		

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 758	<p>Continued From page 52</p> <ul style="list-style-type: none"> * Depression was present. * Antipsychotic and antidepressant medications were received on 7 of the past 7 days. <p>Resident #49's physician orders, dated 8/9/18, documented the following:</p> <ul style="list-style-type: none"> * Alprazolam tablet 0.5 mg by mouth as needed for anxiety, up to three times per day. * Duloxetine HCL capsule Delayed Release 90 mg in the morning related to major depressive disorder. * Quetiapine Fumarate tablet 25 mg 0.5 tablet as needed for insomnia at bedtime. * Vraylar capsule 6 mg in the morning related to major depressive disorder. * Doxepin HCL capsule 10 mg as needed for insomnia once daily at bedtime. <p>Resident #49's current care plan documented the following:</p> <ul style="list-style-type: none"> * The resident used psychotropic medications related to depression. * Administer medications as ordered, and monitor/document side effects and efficacy. <p>Resident #49's July and August 2018 MARs documented the following:</p> <ul style="list-style-type: none"> * Duloxetine capsule Delayed Release 90 mg was administered in the morning each day from 7/17/18 - 7/31/18 and 8/1/18 - 8/8/18. * Vraylar capsule 6 mg was administered in the morning each day from 7/17/18 - 7/31/18 and 8/1/18 - 8/8/18. * Alprazolam tablet 0.5 mg was administered on 7/30/18 and 8/1/18. 	F 758			

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 758	<p>Continued From page 53</p> <p>* Quetiapine Fumarate tablet 25 mg 0.5 tablet was administered on 7/31/18.</p> <p>* Doxepin HCL capsule 10 mg was administered at bedtime on 8/5/18.</p> <p>On 8/9/18 at 2:20 PM, Resident #49 said he was aware he received psychotropic medications, and the facility did not talk to him about the medications or ask him if he was okay with taking them.</p> <p>On 8/9/18 at 4:00 PM, UM #1 said there was no documentation on Resident #49's Psychoactive Medication Informed Consents regarding dosage, frequency, purpose, beneficial side effects, possible side effects, or proposed course of the medications. UM #1 said it was not indicated on the consent forms whether or not the resident consented to the medications, and it looked like facility staff talked to the Resident #49's family member but did not talk to the resident. UM #1 said the facility's process was to read the consent form to the resident, discuss it with the resident and ask if they want to take the medication or not. UM #1 said usually she was the one who completed the Psychoactive Medication Informed Consents with the resident, but she did not work on the day Resident #49's consents were signed. UM #1 said there was no documentation of monitoring behaviors for anxiety for Resident #49.</p> <p>2. Resident #31 was readmitted to the facility on 7/30/18 with multiple diagnoses, including major depressive disorder, recurrent, moderate, and generalized anxiety disorder.</p> <p>Resident #31's quarterly MDS assessment, dated</p>	F 758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
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F 758	<p>Continued From page 54 6/20/18, documented the following:</p> <ul style="list-style-type: none"> * She was cognitively intact. * Anxiety disorder and depression were present. * Antipsychotic, anti-anxiety, and antidepressant medications were administered on 7 of the past 7 days. <p>Resident #31's physician orders, dated 8/3/18, documented the following:</p> <ul style="list-style-type: none"> * Abilify (antipsychotic medication) tablet 15 mg one time a day for major depression. * Lorazepam (anti-anxiety medication) tablet 1 mg as needed for anxiety each night. * Sertraline (antidepressant medication) tablet 100 mg give 1.5 tablets once a day for depression. <p>Resident #31's current care plan documented the following:</p> <ul style="list-style-type: none"> * A long history of depression and anxiety. * "Monitor for agitation/irritability as evidenced by repetitive complaints..." * Monitor for signs and symptoms of depression, exhibited by hopeless statements/tearfulness. * Observe for changes in mood status. <p>Resident #31's July and August 2018 MARs documented Lorazepam (also known as Ativan) tablet 1 mg was administered at bedtime each day from 7/1/18 through 7/31/18, and 8/1/18 through 8/9/18.</p> <p>Resident #31's July and August 2018 behavior monitoring flowsheets documented "Monitor for agitation/irritability" every shift. The flowsheets</p>	F 758			

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

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F 758	<p>Continued From page 55 did not address anxiety.</p> <p>On 8/9/18 at 4:27 PM, UM #1 said Resident #31's Lorazepam order was changed on 8/3/18. UM #1 said Resident #31's anxiety and need for Ativan (Lorazepam) were related to her CPAP (Continuous Positive Airway Pressure) mask being applied each night, and the behavior monitoring flowsheet should probably be more specific about anxiety.</p> <p>3. Resident #34 was admitted to the facility on 6/18/18. The resident's 6/14/18 Abbreviated Level 2 PASRR (Preadmission Screening and Resident Review) Screening for Nursing Facility Placement documented 2 current diagnoses of severe mental illness, major depressive disorder and somatic delusion; and a 6/19/18 H & P documented depression.</p> <p>Resident #34's hospital medication profile report, dated 6/14/18, documented three psychoactive medications were to be continued. The three psychoactive medications were Celexa (antidepressant) 10 mg daily, Wellbutrin (antidepressant) 100 mg three times daily, and Risperdal (antipsychotic) 0.25 mg twice daily. The Celexa and Wellbutrin were both ordered for depression and the Risperdal was ordered for somatic delusion disorder.</p> <p>Resident #34's June 2018 Skilled Nursing Facility orders documented the same three psychoactive medications at the same dose and frequency.</p> <p>Resident #34's Baseline Care Plan documented "Thinks she is infected [with] bugs" as a behavior concern and that medications included Risperdal</p>	F 758			

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F 758	<p>Continued From page 56 and Celexa. The Baseline Care Plan did not mention the Wellbutrin.</p> <p>Resident #34's comprehensive mood care plan for depression, initiated 6/29/18, included interventions for medications to be administered as ordered and to monitor and document depressive symptoms such as tearfulness and negative statements. The comprehensive care plan did not address the somatic delusion disorder or the use of the antipsychotic medication Risperdal.</p> <p>A Psychosocial Evaluation, dated 6/25/18, documented Resident #34's Celexa and Wellbutrin were for depression and Risperdal was for somatic delusion disorder.</p> <p>A 6/25/18 MRR by a pharmacist recommended the physician discontinue one of Resident #34's antidepressant medications or provide a rationale to continue both antidepressants. The physician did not act upon or respond to the pharmacy recommendation for 45 days.</p> <p>On 7/2/18, the physician ordered an increase of the Celexa to 20 mg daily.</p> <p>Resident #34's active physician orders, as of 8/9/18, included Celexa 20 mg daily, Wellbutrin 100 mg three times daily, and Risperdal 0.25 mg twice daily. On 8/10/18, during the survey and 45 days after the 6/25/18 MRR pharmacy recommendation, the physician agreed with the recommendation and ordered Wellbutrin to be decreased by 50%.</p> <p>Resident #34's June, July, and August 2018</p>	F 758			

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

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F 758	<p>Continued From page 57</p> <p>MARs documented the Celexa, Wellbutrin, and Risperdal were administered as ordered from 6/18/18 through mid day on 8/10/18.</p> <p>There was no documented evidence in Resident #34's clinical record (paper and electronic) that depression was monitored in June 2018 or the somatic delusion disorder was monitored in June, July, or August 2018.</p> <p>Resident #34's July and August 2018 Behavior Monitoring flowsheets for depression included a section to document the number of episodes of signs and symptoms of depression (tearfulness or negative statements) per shift (days, evenings, and nights) every day for 31 days per month. The Behavior Monitoring flowsheets documented Resident #34's depression was not consistently monitored in July and August 2018 as follows:</p> <p>* July 2018 - the number of episodes of depression was blank on 7/10/18, 7/11/18, and 7/31/1 day shift; 7/12/18, 7/13/18 and 7/14/18 evening shift; and 7/3/17 and 7/5/18 night shift.</p> <p>* August 1 to August 7, 2018 - the number of episodes of depression was blank on 8/2/18, 8/3/18, 8/4/18, 8/5/18, 8/6/18 and 8/7/18 day shift; 8/3/18, 8/4/18, and 8/5/18 evening shift; and 8/3/18, 8/4/18, 8/5/18, 8/6/18, and 8/7/18 night shift.</p> <p>On 8/9/18 at 11:15 AM, the SSD said she had not initiated a care plan or a behavior monitoring flowsheet for Resident #34's somatic delusion disorder and that she could not find the resident's depression behavior monitor flowsheet for June 2018.</p>	F 758			

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F 758	Continued From page 58 On 8/10/18 at 12:57 PM, UM #2 said that nurses and CNAs monitored residents for behaviors. UM #2 said CNAs documented in the Behavior Monitors (flowsheets) & nurses' documentation could be in multiple places, such as progress notes and/or where CNAs document cares. UM #2 reviewed Resident #34's clinical record and said she did not find nursing or CNA documentation about depression for June 2018. UM #2 said Resident #34's depression was not consistently monitored in July or August 2018 and she did not find documentation the somatic delusion disorder was monitored at all.	F 758			
F 880 SS=D	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	F 880		9/25/18	

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F 880	<p>Continued From page 59 standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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 infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (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. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 60 infection.</p> <p>§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 and interview, it was determined the facility failed to ensure the staff consistently followed hand hygiene practices consistent with accepted standards of practice. This was true for 1 of 12 sample residents (#44) observed receiving direct resident care by staff. Failure to perform hand hygiene between glove changes during incontinence care and proper hand washing after incontinence care, created the potential for infections to develop from cross contamination of infection causing organisms. Findings include:</p> <p>On 8/9/18 at 9:49 AM, CNA #5 and CNA #6 were observed as they performed an incontinence check for Resident #44 who was in bed. The resident was incontinent of bowel and bladder and the CNAs proceeded to provide incontinence care. With her gloved right hand, CNA #5 cleaned feces off the resident's rectal and buttock areas. Using the same gloved right hand, CNA #5 opened Resident #44's closet door, removed a new incontinence brief, then helped CNA #6 place the brief under the resident. After that, CNA #5 removed her used gloves and applied a new pair of gloves. CNA #5 did not perform hand hygiene between the glove change. CNA #5 resumed assisting CNA #6 to care for Resident #44. CNA #5 briefly rubbed Resident #44's back as CNA #6 applied barrier cream to the resident's perirectal area and buttocks, after which CNA #5</p>	F 880	<p>Resident Specific: The clinical management team reviewed resident #44 for evidence of infection, no sign and symptoms were identified. CNAs were provided additional education on proper standard precautions.</p> <p>Other Residents: The clinical management team reviewed other residents during rounds for breach in infection control practices. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses and CNAs are educated to hand hygiene and glove use. Re-education was provided by the Director of Nursing Services and/or designee to include but not limited to hand washing, glove use/change process, environmental contamination, and standard precautions. The system is amended to include surveillance of hand hygiene practices.</p> <p>Monitor: The Director of Nursing Services and/or designee will observe 5 CNAs for hand hygiene weekly for 4 weeks, then 3 weekly for 8 weeks. Starting the week of</p>		

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F 880	Continued From page 61 picked up the tube of barrier cream, squeezed out a small amount of the cream and rubbed it on the resident's back. CNA #5 then removed her gloves and went into Resident #44's restroom. CNA #5 came out of the restroom in less than 10 seconds. CNA #5 assisted CNA #6 to secure Resident #44's incontinence brief, reposition him onto his back, place pillows on each side of him, and to pull the sheet and blanket over the resident. On 8/9/18 at 10:02, CNA #5 said she should have sanitized or washed her hands between the glove change during the incontinence care for Resident #44, but that she did not. CNA #5 said she did wash her hands when she was in Resident #44's restroom but she was "in a hurry" and did not wash her hands for 15 seconds like she should have. CNA #6 was also present and said staff are trained to wash their hands for 20 seconds. A 6/25/18 update by the CDC documented hand hygiene should be done, "After glove removal" and, "When cleaning your hands with soap and water, wet your hands first with water, apply...product recommended...rub your hands together vigorously for at least 15 seconds...rinse...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning you hands at the right times."	F 880	September 18, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks as it deems appropriate.		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		9/25/18	

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F 883	<p>Continued From page 62</p> <p>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(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;</p> <p>(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;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(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;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative</p>	F 883			

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F 883	<p>Continued From page 63</p> <p>has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and facility policy review, the facility failed to ensure that residents received the annual influenza vaccination and the second pneumococcal vaccine per the CDC (Center for Disease Control) recommendations. This was true for 1 of 5 residents (# 5) reviewed for immunizations. These failures placed residents at increased risk of serious illness from influenza and pneumonia. Findings include:</p> <p>The CDC website, accessed 8/15/18, documented recommendations for influenza vaccination and Pneumococcal vaccination (PCV13 or Prevnar 13®, and PPSV23 or Pneumovax 23®) as follows:</p> <p>* Adults 65 years or older who have not previously received PCV13 should receive a dose of PCV13 first, followed at least one year later by a dose of PPSV23.</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after the most recent dose</p>	F 883	<p>Resident Specific: The clinical management team offered Resident #5 the pneumococcal vaccination and resident declined. The resident record reflects the risk and benefit education.</p> <p>Other residents: The clinical management team offered pneumococcal vaccinations to current residents. Those who consented were provided the vaccination. The resident record reflects risk and benefit education those that declined.</p> <p>No influenza vaccinations were offered as 2018-19 season are not yet available. They will be offered during CDC recommended influenza season.</p> <p>Facility Systems: Licensed nurses are educated to influenza and pneumococcal vaccinations. Re-education was provided</p>		

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F 883	<p>Continued From page 64 of PPSV23.</p> <p>* Routine annual influenza vaccination is recommended for all individuals at least six months of age who do not have contraindications to receiving the vaccine.</p> <p>The facility's policy and procedure for the Pneumococcal Program, dated 10/31/17, documented the following:</p> <p>* Two kinds of vaccine are available-Prevnar 13 (PCV13) and PPSV 23 (Pneumovax 23).</p> <p>* Residents or their representative would be educated about pneumococcal vaccine and a copy of the vaccine information statement would be provided.</p> <p>* Residents would be screened for a history of anaphylactic (severe allergic) reaction to previous doses and/or their status in the vaccine series.</p> <p>* The vaccine would be offered to the resident or their representative. If the vaccine was refused, the resident or their representative would be re-educated and the refusal would be documented on the immunization record.</p> <p>The facility's policy and procedure for the Influenza Program, dated 10/31/17, documented the following:</p> <p>* During flu season, "...residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area."</p> <p>* Residents would be screened to determine the residents who are eligible and desire to receive the vaccine.</p> <p>* The vaccine information sheet would be</p>	F 883	<p>by the Director of Nursing Services and/or designee to include but not limited to, logging vaccinations and manage due dates as indicated, validate each resident receives influenza vaccination as desired including new admissions. The system is amended to include review of vaccination schedule with care conference and trended through infection control committee.</p> <p>Monitor: The Director of Nursing Services and/or designee will audit new admissions and the pneumococcal tracking log for provision of immunization per schedule monthly for 3 months. Starting the week of September 25, 2018 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p>		

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/10/2018
NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 883	<p>Continued From page 65</p> <p>reviewed with the resident or their representative.</p> <p>* The influenza vaccine would be offered to the resident or their representative.</p> <p>* If the resident or their representative refused the vaccine, it would be documented on the immunization record.</p> <p>Resident #5 was admitted to the facility on 9/2/10 with multiple diagnoses, including unspecified dementia with behavioral disturbance, adult failure to thrive, and muscle weakness.</p> <p>Resident #5's annual MDS assessment, dated 12/1/17, and quarterly MDS assessments, dated 2/22/18 and 5/11/18, documented the influenza vaccine was administered on 10/17/17 and the pneumococcal vaccine was up to date.</p> <p>Resident #5's physician orders, dated 6/28/18, documented "Administer Flu vaccine annually," was ordered on 8/5/17.</p> <p>Resident #5's Immunization Record documented the influenza vaccine was last administered on 10/19/16, and the Pneumovax 23 was administered on 12/18/10.</p> <p>On 8/8/18 at 10:52 AM, UM #1 said she would have to look it up regarding Resident #5's pneumonia and influenza vaccines. UM #1 said they just vaccinated everybody and she was not sure if Resident #5 was on the list.</p> <p>The facility did not provide documentation of Resident #5 receiving the influenza vaccine since 2016 or the pneumonia vaccine since 2010.</p>	F 883			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 31, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **August 10, 2018**, an unannounced on-site complaint survey was conducted at Wellspring Health & Rehabilitation Of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007753

Allegation #1: Residents did not receive prepared food they can eat and are not being offered an alternative meal.

Findings #1: Staff were observed passing meal trays to residents in their rooms, assisting with the meal service, and offering alternative food to the residents. No concerns were identified during the observation. One resident was observed requesting an alternate meal and she received it.

Several residents were observed during meal times and no concerns were identified.

Several residents were interviewed and they did not have concerns regarding meals being prepared or alternative meals being offered.

Nurses and CNAs were interviewed and they stated they made sure residents had their meals prepared, the food tasted good, or the resident was offered an alternative meal before leaving the room. The Dietary Manager was interviewed and stated she ensured the meals were presentable and residents were able to eat the meal. The Dietary Manager stated if the resident was not satisfied with the meal, then staff offered an alternative meal.

The allegation could not be substantiated due to lack of evidence that the facility did not provide foods the residents could eat or offer alternative meals to the residents.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility did not notify the responsible party when the resident had a change of condition.

Findings #2: The records of 4 residents were reviewed, facility policy was reviewed, and residents and staff were interviewed.

The facility's policy for Resident Change of Condition, dated 11/28/17, stated the facility was to notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status. This policy was not followed.

One resident was reviewed who had multiple diagnoses, including low blood pressure and kidney failure. The resident went to dialysis at an outside facility three times a week.

A Progress Note, dated 7/23/18 at 9:06 AM, documented the resident exhibited a change in condition exhibited by confusion, disorientation, elevated blood pressure, and complaints of dizziness and not feeling "right." The healthcare provider was notified and an ambulance was called but the resident refused to go to the hospital at that time.

A subsequent Progress Note, dated 7/23/18 at 2:24 PM, documented the dialysis center called the facility and said the resident was "still very confused and not oriented" during the dialysis treatment and they were going to transfer her to the hospital after the treatment that day. The resident was admitted to the hospital at that time.

There was no documentation in the resident's record her representative was notified of her transfer to the hospital from the dialysis center.

On 8/9/18, the resident said she was hospitalized recently due to a urinary tract infection. She said she did not remember anything for three days after that.

On 8/10/18, a Unit Manager said she notified the resident's representative of the transfer to the hospital from the dialysis center but there was no documentation of the conversation.

The allegation was substantiated and cited at F580 related to the facility's failure to notify the responsible party when a resident had a change of condition.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: Clinical records were not received in a timely manner after they were requested by a resident representative.

Findings #3: Resident representatives were interviewed regarding requests for clinical records and no concerns were identified.

The records of several residents were reviewed for records requests and no concerns were identified or documented in the records.

Staff were interviewed regarding requests for copies of resident records. The staff stated they referred representatives to Medical Records to fill out the proper paperwork to receive the requested documents.

The Medical Records Representative was interviewed and stated a "HIPAA Release of Information Authorization Form" was required to be filled out and the documents were then copied for the representative. The Medical Records Representative said if the forms were not filled out the copies were not released.

The allegation could not be substantiated due to lack of evidence that clinical records were not received in a timely manner after they were requested.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Residents' call lights were not answered in a timely manner.

Findings #4: Call lights were observed throughout the survey and no concerns were identified. Staff responded to call lights within three minutes or less in one hall.

Resident Council minutes were reviewed and no concerns regarding call lights were identified. The facility's grievance files were reviewed and no concerns regarding call lights were identified.

Residents were interviewed and no concerns were identified regarding call lights. CNAs, Nurses, and Nurse Managers were interviewed and they said they made sure residents' call lights were answered promptly.

The allegation was not substantiated due to lack of evidence that the facility did not answer call lights promptly.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The licensed staff were not providing wound care to residents at the facility according to physician's orders.

Findings #5: Residents were observed and interviewed, records were reviewed, staff were interviewed, and wound care was observed during the survey.

One resident was observed declining wound care to his legs three different times during the survey. Nurses were observed reapproaching the resident to have wound care completed and educating the resident regarding the importance of receiving wound care. The resident continued to decline wound care. The resident was offered pain medication prior to wound care and the resident stated he was not in pain.

The resident's clinical record was reviewed. The clinical record documented the resident refused to have wound care treatment completed on several occasions from January 2018 to August 2018. The resident had an order for Triact dressing to the wounds from mid January to February, and received the wound care treatment with a dressing equivalent to Triact.

Three residents were observed receiving wound care and no concerns were identified. The 3 residents were interviewed regarding wound care, receiving the correct treatment as ordered by the physician, and whether they were offered pain medications prior to wound care treatment. The three residents did not have concerns with wound care management.

Several nurses were interviewed and stated if the facility did not have a specific dressing medication per the physician's orders, the facility special-ordered the dressing and assured an equivalent product was used until the brand name was delivered. The nurses stated when residents refused wound care treatment, they educated the resident about the importance of the treatment to be completed, offered pain medication prior to treatment, and set times that would work best for the resident.

The allegation was not substantiated due to lack of evidence that the facility was not providing wound care.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegations #6: The facility was not transcribing physician orders correctly.

Findings #6: During the survey, staff were observed and interviewed, and resident records were reviewed.

Licensed staff were observed throughout the survey passing medications, including narcotic medication, with no concerns identified.

Several residents' records were reviewed for medication orders and dosages, and no concerns were identified.

Nurses and Nurse Managers were interviewed regarding reordering narcotics and transcribing medications. The nurses stated if the resident was out of a narcotic medication, they contacted the physician to obtain a new prescription to be provided to the pharmacy. The pharmacist authorized the order with a number for the nurse to obtain the narcotic medication in the facility's emergency kit until the pharmacy filled the prescription.

The allegation was not substantiated due to the lack of evidence that the facility did not transcribe physician orders correctly.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The facility did not address a resident's bowel symptoms.

Findings #7: The facility had posted written notification of gastrointestinal symptoms being identified in the building and contact precautions were in place. Precaution signs were posted at the facility's entrance door and throughout the facility for staff and visitors to use a mask, gown, and handwashing.

The records of several residents were reviewed. The facility identified the gastrointestinal symptoms in residents, and the physician was contacted for orders.

Several CNAs, nurses, and nurse managers were observed providing care to the residents using contact precautions with no concerns identified.

Several CNAs, nurses, and nurse managers were interviewed and stated the residents were under contact precautions and the physician's orders were followed.

Debbie Mills, Administrator
January 31, 2019
Page 6 of 6

It was determined the facility identified the gastrointestinal symptoms and treated the resident appropriately. The allegation was not substantiated.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 31, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **August 10, 2018**, an unannounced on-site complaint survey was conducted at Wellspring Health & Rehabilitation Of Cascadia. The complaint allegation, findings and conclusion are as follows:

Complaint #ID00007898

The alleged complaint was investigated in conjunction with a Federal recertification and State licensure survey conducted at the facility on August 6, 2018 through August 10, 2018.

The survey team reviewed the clinical records of eight residents who were hospitalized. Four staff members were interviewed.

Allegation: The facility refused to readmit a resident after a hospitalization.

Findings: Review of one resident's record documented she was discharged from the facility during a hospitalization and was not given at least thirty days' notice prior to the discharge, as required by regulation.

Debbie Mills, Administrator
January 31, 2019
Page 2 of 2

The identified resident was originally admitted to the facility on 9/26/17. She was readmitted on 2/19/18 with multiple diagnoses including acute and chronic respiratory failure with hypoxia (condition or state in which the supply of oxygen is insufficient for normal life functions), bacterial pneumonia, and diabetes mellitus due to underlying condition with diabetic chronic kidney disease. She also had a history of acute and chronic pain, dysphagia (difficulty swallowing), and cognitive communication deficit.

The identified resident was dependent on staff for care and activities of daily living. During her facility stay, the resident was transferred to a local acute care hospital at the family's request due to a change in her condition. Thirteen days after the resident was transferred to the hospital, the resident's family member was notified that the facility would not accept the resident back, and it would be necessary to find another facility to accept the resident. Facility administration stated they would not accept the resident back from the hospital because the resident's family member would not agree to conditions the facility would require in order for the resident to return.

Fourteen days after being transferred to the hospital, the resident was transferred to a facility in another state.

Based on the investigative findings, the allegation was substantiated, and Federal deficiencies were cited at F 623 as it related to the failure of the facility to ensure residents were provided with the required notice prior to being discharged.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

Debbie Mills, Administrator
January 31, 2019
Page 3 of 2

LT/pmt