



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 15, 2019

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

Provider #: 135094

Dear Ms. Mills:

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

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

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

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

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

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

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

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

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

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

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2019** includes the following:

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

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

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

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

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

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

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

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<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:

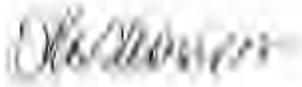
- BFS Letters (06/30/11)

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

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

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

Sincerely,



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

lt/dr

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

PRINTED: 04/01/2019
FORM APPROVED
OMB NO. 0938-0391

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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 03/01/2019 |
| 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 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey and complaint investigation conducted at the facility from February 25, 2019 through March 1, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Jenny Walker, RN Wendi Gonzales, RN</p> <p>Abbreviations:</p> <p>DNS = Director of Nursing Services BID = Twice a day BP = Blood pressure CHF = Congestive heart failure ESRD = End stage renal disease LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = Milligram(s) PRN = As needed RN = Registered Nurse UM = Unit Manager</p> | F 000 | | | |
| F 568 SS=E | <p>Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii)</p> <p>§483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> | F 568 | | 4/5/19 | |

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

TITLE

(X6) DATE

Electronically Signed

03/25/2019

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 568 | <p>Continued From page 1</p> <p>(C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:</p> <p>Based on family and staff interview, and record review, it was determined the facility failed to provide a financial record, or quarterly statement, to 5 of 6 residents (#5, #6, #11, #37, and #49) whose personal fund accounts were reviewed. The failure created the potential for harm if concerns, including inaccuracies, about the personal fund accounts were not addressed. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 9/2/10, with multiple diagnoses including dementia and adult failure to thrive.</p> <p>On 2/26/19 at 2:08 PM, Resident #6's representative said the facility held a personal fund account for her but she had not received a quarterly statement for the account for about a year.</p> <p>On 2/27/19 at 2:29 PM, the Business Office Manager (BOM) said the facility held a personal fund account for Resident #6. The BOM said she did not keep a copy of Resident #6's account statements or when she mailed them to Resident #6's representative.</p> <p>On 2/27/19 at 3:31 PM, the BOM said Resident #6's representative verified the facility had her correct mailing address and confirmed she had not received a fund account statement for about 1 year.</p> | F 568 | <p>F568 Resident Specific Residents #5, 6, 11, 37 and 49 had their individual financial record for the trust fund provided to them and/or personal representative. Documentation is maintained for business office records.</p> <p>Other Residents The business office manager or designee reviewed other residents with resident trust funds and provided copies of their personal quarterly financial statement. Documented evidence is maintained in the business office records.</p> <p>Facility Systems Business office manager was educated by Executive Director on requirement to provide at least quarterly statements and to maintain copy of date of mailing/delivery when indicated. They system is amended to include the Executive Director to review at least quarterly.</p> <p>Monitor The Executive Director and/or designee will audit residents with trust fund accounts quarterly statements. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the</p> | | |

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| F 568 | Continued From page 2 2. The facility did not have documentation personal fund account statements were provided to residents or their representatives for Resident #5, #11, #37, and #49. On 2/26/19 at 2:08 PM, the BOM said she did not keep copies of residents' personal fund account statements. She said the company that managed resident fund accounts sent quarterly statements to the facility for each resident who had an account. She said if the address on the statement was the same as the facility's address, the statement was hand delivered to the resident, if the address was different from the facility's address, the statement was mailed to the person addressed on the statement. On 2/27/19 at 2:45 PM, the Administrator provided a list of 25 residents for whom the facility held a personal fund account. At 3:31 PM, the BOM reviewed the list and said she mailed personal fund account statements to the representative for 6 of the 25 residents. The BOM said she did not keep a record of when she mailed the fund account statements. On 2/27/19 at 3:50 PM, the BOM provided a copy of Resident #49's personal fund account statement for 10/1/18 to 12/31/18 with the name and address of her representative. On 2/28/19 at 8:45 AM, the BOM said she did not have documentation she mailed quarterly personal fund account statements to the residents, or their representatives, who received the statements by mail. | F 568 | frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance 4/5/2019 | | |
| F 622 SS=D | Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) | F 622 | | 4/5/19 | |

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| F 622 | Continued From page 3 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health | F 622 | | | |

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| F 622 | <p>Continued From page 4</p> <p>or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for</p> | F 622 | | | |

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| F 622 | <p>Continued From page 5</p> <p>ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations for 3 of 4 residents (#2, #39, and #52) reviewed for transfers. The deficient practice had the potential to cause harm if the residents did not receive the appropriate care and services in a timely manner due to the lack of information. Findings include:</p> <p>1. Resident #2 was readmitted to the facility on 2/13/19, with multiple diagnoses including a heart attack.</p> <p>A discharge MDS assessment, dated 2/7/19, documented Resident #2 was discharged to an acute hospital.</p> <p>A Nursing Progress Note, dated 2/7/19 at 5:58 AM, documented Resident #2 was not breathing, no pulse was detected, CPR (cardiopulmonary resuscitation) was initiated, and 911 was called.</p> <p>Resident #2's record did not include documentation his physician was notified or information regarding his status was conveyed to the hospital.</p> <p>On 2/27/19 at 10:13 AM, UM #2 stated when a</p> | F 622 | <p>F622</p> <p>Resident Specific</p> <p>Resident #2, 39, and 52, who are currently in facility, will have the required documentation completed and the appropriate information communicated to receiving facility if discharge should occur. After review, no negative outcomes were identified for these residents.</p> <p>Other Residents</p> <p>All current residents will have the required documentation completed and the appropriate information communicated to receiving facility if discharge should occur. No current residents are in the hospital. No additional documentation is required.</p> <p>Facility Systems</p> <p>Licensed nurses were educated by Director of Nurses or designee on facility transfer and discharge policy including but not limited to process to show evidence of information shared with receiving facility, documentation for physician notification, and documentation of communication shared with transport</p> | | |

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| F 622 | <p>Continued From page 6</p> <p>resident was transferred to an Emergency Room (ER) or hospital, the facility provided two copies of the resident's face sheet, medication list, H&P (History and Physical, contains medical history information and the physical assessment of the resident by a health care provider), change of condition, code status, and the order to transport to the ER/hospital. He said one copy went to the paramedics and the other copy was for the ER/hospital. The DNS and UM#2 stated Resident #2's record did not include documentation he was sent to the hospital via ambulance, clinical information/paperwork was provided to the paramedics or ER/hospital, or the reason for the transfer to the hospital.</p> <p>2. Resident #39 was readmitted to the facility on 1/4/19, with multiple diagnoses including pneumonia.</p> <p>A discharge MDS assessment, dated 12/30/18, documented Resident #39 was discharged to an acute care hospital.</p> <p>A Nursing Progress Note, dated 12/30/18 at 4:34 PM, documented Resident #39 had a change of condition, the physician was notified and ordered to have Resident #39 transferred to the hospital for further evaluation.</p> <p>Resident #39's record did not include documentation the hospital was notified of the transfer or information/paperwork regarding Resident #39's status was sent to the hospital.</p> <p>On 2/27/19 at 1:59 PM, the DNS stated Resident #39's record did not include documentation the paperwork was provided to the paramedics, a</p> | F 622 | <p>as indicated . The system is amended to include review in clinical meeting of the required documentation of residents who are transferred or discharged from facility that is evident in the clinical record.</p> <p>Monitor The Director of Nursing or designee will audit for completion of evidence in the clinical record of required documentation for residents who are transferred or discharged weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p> | | |

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| F 622 | <p>Continued From page 7</p> <p>verbal or written report was sent to the hospital staff, or the reason for admission to the hospital.</p> <p>3. Resident #52 was admitted to the facility on 2/24/17, with multiple diagnoses including multiple sclerosis. She was readmitted on 11/13/18 and 1/15/19 following unplanned hospitalizations.</p> <p>On 2/26/19 at 9:42 AM, Resident #52 stated she was admitted to a hospital a couple of times in the recent past.</p> <p>Resident #52's MDS assessments, dated 11/9/18 and 1/11/19, documented she had unplanned discharges to a hospital both times.</p> <p>A progress note, dated 11/19/18 at 3:50 AM, documented Resident #52 had multiple episodes of dark brown emesis throughout the night and was unable to tolerate anything by mouth and had an elevated temperature and blood pressure. The on-call physician was notified and ordered for Resident #52 to go to the ER for evaluation. Resident #52's record stated the hospital was contacted and a report was given to an ER nurse.</p> <p>There was no documentation clinical records or information was provided to the non-emergent transport staff or the receiving ER/hospital staff for Resident #52.</p> <p>A progress note, dated 1/11/19 at 5:25 AM, documented Resident #52 had 2 episodes of dark brown emesis. The progress note documented the physician was notified. At 8:03 AM, the physician ordered Resident #52 be</p> | F 622 | | | |

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| F 622 | Continued From page 8 transported to an ER. There was no documentation in Resident #52's record verbal or written report was given or clinical records were provided to the ambulance crew or the receiving ER/hospital staff. On 2/27/19 at 10:34 AM, UM #1 said when a resident was sent to an ER or hospital, the staff sent the resident's face sheet, medication list, H&P, code status, and the order to transport, and a nurse called and gave report to the ER/hospital staff. UM #1 said Resident #52 was hospitalized on 11/9/18 and 1/11/19 for gastrointestinal bleeding. UM #1 said she did not find documentation a verbal or written report was given to the ambulance crew or the ER/hospital staff on 1/11/19 and she did not find documentation clinical information/records were provided to the ambulance crew or ER/hospital staff when Resident #52 went to an ER on 11/9/18 and 1/11/19. | F 622 | | | |
| F 657 SS=D | Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. | F 657 | | 4/5/19 | |

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| F 657 | <p>Continued From page 9</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review, and review of facility/dialysis provider agreement, it was determined the facility failed to ensure care plans were reviewed and revised after each comprehensive assessment and as needed by an interdisciplinary team for 1 of 2 residents (Resident #38) reviewed for dialysis services. The failure created the potential for harm if care and services were not provided to a resident as needed. Findings include:</p> <p>The facility's care plan policy, dated 11/28/17, documented each resident's person-centered, comprehensive care plan would be reviewed and revised by an interdisciplinary team "composed of individuals who have knowledge of the resident and their needs," including the resident, their representative, the physician or designee, facility staff, and "Other appropriate staff as determined by the resident's needs..." Further, it documented care plans are reviewed "after each assessment except discharge assessments, and</p> | F 657 | <p>F657 Resident Specific Resident #38's care plan was reviewed by clinical management team and care plan was updated to maintain consistency and accuracy with dialysis treatments/orders.</p> <p>Other Residents Residents receiving dialysis had care plans reviewed by clinical management team validate care plans accurately reflect care and services for dialysis.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses or designee regarding facility coordination with Dialysis validate resident care plans are updated for dialysis treatments/orders. The system is amended to include clinical management team in clinical meeting to review and</p> | | |

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| F 657 | <p>Continued From page 10 revised based on changing goals, preferences and needs of the resident and in response to current interventions."</p> <p>The facility's dialysis policy, dated 11/2017, documented there should be development of a coordinated plan for dialysis treatments with input from both the nursing facility and dialysis provider.</p> <p>The facility/dialysis provider agreement, effective 5/7/18, documented mutual obligations included documented evidence of the collaboration of care and communication between the facility and dialysis provider. The agreement also stated the documentation shall include participation by members of an interdisciplinary team, in care conferences, with signatures of team members from both parties on short and long-term care plans.</p> <p>Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD requiring dialysis and CHF (heart failure).</p> <p>Resident #38's quarterly MDS assessment, dated 1/14/19, documented her cognition was intact and she was on dialysis.</p> <p>A nursing progress note, dated 1/21/19 at 4:10 PM, documented Resident #38 returned to the facility after placement of a hemodialysis access device to her right upper arm and the vascular catheter in her right chest was still present.</p> <p>Resident #38's care plan for dialysis included the right upper chest port for dialysis and to monitor her BP before and after dialysis. There was no</p> | F 657 | <p>update of care plan for dialysis residents after appointments, consultations, and or physician directives.</p> <p>Monitor The Director of Nurses or designee will audit residents receiving dialysis care plans weekly x 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p> | | |

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| F 657 | Continued From page 11 documentation she had a device in her right arm. On 2/26/19 at 2:43 PM, LPN #1 said Resident #38 went to dialysis on Monday, Wednesday, and Friday. LPN #1 said Resident #38 had 3 dialysis access devices, one in her left upper arm that was not functional, a vascular catheter (a surgically inserted central venous catheter) in her right chest that was giving out, and the newest site was in her right upper arm. On 2/27/19 at 1:47 PM, RN #1 said the facility staff checked Resident #38's BP in her legs, not her arms, because she had a dialysis access device in each arm. RN #1 said Resident #38's care plan did not document the presence of the new access device in her right upper arm, the non- functioning access device in her left arm, or to check her BP in her legs, not her arms. On 2/28/19 at 2:04 PM, UM #1 said Resident #38's care plan should have been revised when the right upper arm dialysis access device was placed on 1/21/19. She said the care plan also should have been revised when it became necessary to check her BP in her lower extremities, not her arms. | F 657 | | | |
| F 684 SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered | F 684 | | 4/5/19 | |

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| F 684 | <p>Continued From page 12 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were provided for 2 of 16 residents (#38 and #45) whose medications were reviewed. The failure created the potential for harm when medication was not administered as ordered and was not monitored for potential adverse side effects. Findings include:</p> <p>1. Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD and chronic CHF.</p> <p>Resident #38's care plan documented she had impaired cardiac function related to CHF and a history of high and low BP. Interventions included monitoring her BP twice daily, before and after dialysis sessions, and to administer medications as ordered, which were initiated 12/17/18.</p> <p>Resident #38's physician orders included Clonidine (high BP medication) 0.2 mg by mouth 2 times a day PRN if her systolic blood pressure (SBP, the top number on a BP reading) was greater than 160, ordered 11/21/18, and to check her BP 2 times per day and provide Clonidine as ordered PRN, ordered 11/29/18.</p> <p>Resident #38's record documented her SBP was greater than 160 on 13 occasions in February 2019. Clonidine was not administered as ordered 9 out of 13 times for an SBP greater than 160. The Clonidine was not administered when Resident #38's SBP was 179 on 2/6/19, 162 on</p> | F 684 | <p>F684 Resident Specific Education provided to nurses who provided medication administration for residents #38 and 45 to ensure understanding of medication administration policy to include but not limited to blood pressure medications administered based on parameters and anticoagulant therapy side effects monitoring. No adverse reactions are observed for these residents.</p> <p>Resident #38's physician has been notified regarding the medication provided outside of parameters. No additional directives were provided.</p> <p>Other Residents The clinical management team reviewed medication administration through random medication pass audits and blood pressure parameter reports completed on or before April 5, 2019 by Director of Nurses or designee. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated by the Director of Nursing or designee regarding medication administration to include but not limited to blood pressure medications administered based on parameters and anticoagulant therapy side effects monitoring.</p> | | |

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| F 684 | Continued From page 13 2/8/19, 173 on 2/10/19, 179 on 2/13/19, 183 on 2/15/19, 163 on 2/17/19, 166 on 2/18/19, 172 on 2/19/19, and 163 on 2/24/19. On 2/28/19 at 2:04 PM, UM #1 reviewed Resident #38's record and said the Clonidine was not administered as ordered when her SBP was greater than 160. 2. Resident #45 was admitted to the facility on 12/27/18, with multiple diagnoses including pleural effusion, dysphagia (difficulty swallowing), and a history of falling. A physician order for Resident #45, dated 1/24/19, included the anticoagulant medication Eliquis 2.5 mg by mouth 2 times a day to help prevent blood clots. There were no orders to monitor him for signs and symptoms of adverse reactions, such as easy or excessive bruising, bleeding from the gums or in the urine, or internal or uncontrolled bleeding. Resident #45's care plan did not include or address the use of the anticoagulant medication and there was no documentation in his record he was monitored for potential adverse reactions while he was taking the Eliquis. 02/28/19 03:20 PM, UM #1 said there was no order or care plan to monitor Resident #45 for signs and symptoms of potential adverse reactions related to the use of Eliquis. | F 684 | Monitor The Director of Nursing or designee will monitor blood pressure parameter reports, review new anticoagulant orders for side effect monitoring, and audit 3 random medication passes for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance 4/5/2019 | | |
| F 698 SS=D | Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who | F 698 | | 4/5/19 | |

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| F 698 | <p>Continued From page 14</p> <p>require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review, and review of the facility/dialysis provider agreement, it was determined the facility failed to ensure there was consistent collaboration and coordination of care and services between the facility and the dialysis provider. This was true for 1 of 2 residents (Resident #38) reviewed for dialysis services. The failure created the potential for harm if undetected complications went untreated or there was a delay in treatment because of lack of communication and coordination. Findings include:</p> <p>The facility's dialysis policy, dated 11/2017, documented there would be coordination and collaboration between the nursing facility and dialysis provider, including the development of a coordinated plan for dialysis treatments with input from both the nursing facility and dialysis provider.</p> <p>The facility/dialysis provider agreement, effective 5/7/18, documented mutual obligations included collaboration of care with both parties and documented evidence of the collaboration and communication between the facility and dialysis provider. The documentation included participation in care conferences with signatures of team members from both parties.</p> <p>Resident #38 was admitted to the facility on 3/15/17, with multiple diagnoses including ESRD</p> | F 698 | <p>F698 Resident Specific Resident #38 participated in care conference with facility care team and dialysis care team on or before April 5, 2019. Documentation is reflected in the clinical record.</p> <p>Other Residents The clinical management team reviewed additional dialysis patients and provided care conferences between patients, facility care team and dialysis care team on or before April 5, 2019. Adjustments have been made as indicated.</p> <p>Facility Systems Social service manager and licensed nurses were educated by the Director of Nursing to coordination care conference quarterly or with change of condition, dialysis provider information is reflected on the care plan, clear documentation of mediation sent with resident to dialysis and whether resident had medication administered, hemodialysis communication is completed by facility staff, documentation in the clinical record reflects follow-up with dialysis facility when communication is not received post dialysis session. The system is amended.</p> | | |

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| F 698 | <p>Continued From page 15 requiring dialysis and CHF.</p> <p>Resident #38's quarterly MDS assessment, dated 1/14/19, documented her cognition was intact and she was on dialysis.</p> <p>Resident #38's care plan documented she was at risk for complications related to ESRD and hemodialysis. The care plan interventions included the following:</p> <ul style="list-style-type: none"> * Communicate and send Dialysis Communication record to every dialysis appointment. * Coordinate medications and treatments with dialysis appointments. * Notify the dialysis provider (name/phone number given) of any complications. * Observe and record signs/symptoms of infection at site of dialysis port in her right upper chest. <p>a. Care conferences were not coordinated or conducted with staff from the facility and the dialysis center on a regular basis.</p> <p>Resident #38's record documented a care plan conference was conducted on 6/19/18. There was no documentation the staff of the dialysis center were involved in the care plan conference. Additionally, there was no documentation that subsequent, or at least quarterly, care plan conferences occurred for 8 months.</p> <p>On 2/28/19 at 2:04 PM, UM #1 said care conferences were conducted in Resident #38's room to make it easier for her to participate. She said her daughter attended these conferences</p> | F 698 | <p>Monitor</p> <p>The Director of Nursing or designee will audit dialysis patients for coordinated plan of care for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p> | | |

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| F 698 | <p>Continued From page 16</p> <p>sometimes. UM #1 said the dialysis center staff did not attend or participate in care conferences. She said the Social Services Manager (SSM) scheduled and recorded all care conferences.</p> <p>On 3/1/19 at 8:30 AM, the SSM said Resident #38's last care conference was on 6/19/18. She said she did not realize it was that long since a care conference was conducted. The SSM said Resident #38's daughter participated when she was able but the dialysis staff did not participate in the care conferences.</p> <p>b. Resident #38's MARs did not include clear documentation of medications sent with her to dialysis.</p> <p>Resident #38's record included a physician order, dated 11/27/18, to send two Midodrine 2.5 mg tablets with her to dialysis every Monday, Wednesday, and Friday. Midodrine is a medication used to increase blood pressure.</p> <p>Resident #38's MARs for January and February 2019 included areas for documenting when the Midodrine was sent to the dialysis center with her and whether it was given by the dialysis center. The MARs documented Midodrine was sent to dialysis every M-W-F morning, except on Monday 1/21/19 and Monday 2/18/19.</p> <p>The MARs documented Midodrine was not given at dialysis on 1/2/19 or 1/4/19, with a "No" written under the date. The MAR documentation was unclear whether the Midodrine was given at dialysis for the other days in January 2019 and February 2019. The facility staff documented "X", "Y", "No," "RLE," and numbers in the area for</p> | F 698 | | | |

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| F 698 | <p>Continued From page 17 documenting whether the Midodrine was given.</p> <p>The dialysis staff documented Midodrine was administered on 1/23/19, while the facility. The January 2019 MAR documented an "x" in the space for whether it was "taken" at dialysis.</p> <p>On 2/27/19 at 1:47 PM, RN #1 said Resident #38 had problems with her BP and sometimes it was low when she was at dialysis. He said the facility sent 2 Midodrine 2.5 mg tablets with her to dialysis.</p> <p>On 2/28/19 at 2:04 PM, UM #1 reviewed Resident #38's January and February 2019 MARS. She said when Resident #38 returned to the facility without the Midodrine, they assumed it was given at dialysis. She said the MAR documentation was not clear whether or not the Midodrine was given at dialysis. UM #1 said staff did not know if the Midodrine was lost or misplaced. UM #1 said it was the dialysis provider's responsibility to document when they gave the Midodrine.</p> <p>c. Resident #38's record included Hemodialysis Communication forms used by the facility staff and the dialysis staff for documentation pre and post dialysis. The forms included 2 sections for documenting Resident #38's status and condition by staff, and an area for staff to sign, date, and time.</p> <p>The top section, for the facility staff to complete, included areas to document Resident #38's vital signs (BP, pulse, respirations, temperature), weight pre and post dialysis, the vascular access device type, appearance, and whether the graft</p> | F 698 | | | |

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| F 698 | <p>Continued From page 18</p> <p>or fistula had bruit (a swishing sound, indicates patency) and thrill (a vibration, indicates arterial and venous blood flow and patency) were present or not. The section also included an area to document problems since the last treatment, order and/or medication changes, and questions/concerns.</p> <p>The bottom section, for the dialysis staff to complete, included areas to document Resident #38's weight, BP, and temperature pre and post treatment, vascular access device type, appearance, and post treatment bleeding time. The section also included an area for documenting the plan if a permanent access was not present, medications given during dialysis, any adverse events during treatment, physician order changes, and follow-up needed.</p> <p>Resident #38's Hemodialysis Communication forms were not completed by facility staff as follows:</p> <ul style="list-style-type: none"> - Facility staff did not assess her access device dressing on 1/4/19, 1/9/19, and 2/19/19. - Facility staff did not weigh her after dialysis on 1/4/19, 2/8/19, 2/11/19, 2/13/19, 2/18/19, and 2/25/19. - Facility staff did not document the time on 1/4/19, 1/11/19, 1/25/19, 2/8/19, 2/15/19, and 2/22/19. <p>Resident #38's Hemodialysis Communication forms were not completed by dialysis staff as follows:</p> <ul style="list-style-type: none"> - Dialysis staff did not assess her access device dressing on 1/4/19, 1/28/19, and 2/22/19. | F 698 | | | |

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| F 698 | Continued From page 19 - Dialysis staff did not check her post treatment weight/BP/temperature on 1/14/19. - Dialysis staff did not document the time on 1/2/19, 1/4/19, 1/7/19, 1/11/19, 1/14/19, 1/23/19, 1/25/19, 1/28/19, 2/6/19, 2/11/19, 2/15/19, and 2/22/19. - Dialysis staff did not assess her access device, dressing, or monitor her post treatment bleeding time on 2/15/19. There was no documentation the Hemodialysis Communication forms for Resident #38 were returned to the dialysis provider when they were incomplete. On 3/01/19 at 9:09 AM, UM #2 said other than Dialysis Communication sheets, there was no other documentation of coordination and communication between the facility and dialysis provider. | F 698 | | | |
| F 700 SS=D | Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. | F 700 | | 4/5/19 | |

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| F 700 | <p>Continued From page 20</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to ensure alternatives were attempted and safety assessments were completed prior to the installation of side rails on residents' beds. This was true for 2 of 3 residents (#23 and #52) reviewed for the use of side rails. The failure created the potential for harm if residents were to become entrapped in the side rails or sustained injury related to the use of the side rails. Findings include:</p> <p>1. Resident #23 was admitted to the facility on 11/22/17, with multiple diagnoses including muscular dystrophy (progressive weakening and wasting of muscle), lymphedema (swelling of subcutaneous tissues from excessive fluid), and anxiety.</p> <p>Resident #23's care plan documented he required staff assistance with ADLs (activities of daily living). Interventions included a personally owned hospital bed with air mattress, 4 side rails in the raised position per his preference, and the left side rails down as he requested to accommodate his use of personal items.</p> <p>Resident #23's orders included an order, dated 7/18/18, for a Hill Rom specialty bed with air</p> | F 700 | <p>F700 Resident Specific Resident #23 discharged from the facility. The clinical management team reviewed resident #52 for use of side rails updating the bed safety evaluation to include safety assessment and documentation other interventions attempted prior to use of side rails.</p> <p>Other Residents The clinical management team reviewed additional patients that utilize side rails to validate bed safety evaluations to include safety assessment and documentation of other interventions attempted prior to the use of side rails. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses were educated by the Director of Nursing regarding side rail use including but not limited to bed safety evaluations and consents for use of side rails. The system is amended to include clinical management team to review bed safety to include safety assessment and documentation of other interventions prior to the use of side rails with new</p> | | |

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

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

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| F 700 | <p>Continued From page 22</p> <p>needed assistance with all ADLs. The interventions included bilateral bed mobility bars to assist with bed mobility, which was initiated on 6/27/18 and revised on 7/19/18.</p> <p>Resident #52's orders included a bed with an air overlay mattress and minimal mobility bars for increased bed mobility, dated 1/14/19.</p> <p>On 2/26/19 at 9:31 AM and 2/27/19 at 11:11 AM, Resident #52 was observed in bed with an air mattress in place and bilateral "½" side rails in the raised position. Both times she said she used the side rails to move herself and help when the staff repositioned her.</p> <p>Bed Safety Evaluations for Resident #52, dated 11/13/18 and 1/15/19, documented the side rails were in place. The evaluations did not include documentation Resident #52 was assessed to determine if she was safe with the use of the side rails or alternatives were attempted prior to the placement of the side rails.</p> <p>On 2/27/19 at 9:49 AM, UM #1 said when Resident #52 was readmitted on 11/13/18 and 1/15/19 the Bed Safety Evaluations were just continued from a previous Bed Safety Evaluation done on 6/27/18. UM #1 said none of the Bed Safety Evaluations specifically addressed or documented if she was assessed to determine her safety with the use of the side rails or alternative interventions were tried prior to the installation of the side rails. UM #1 said Resident #52's air mattress did not require side rails. The UM reviewed Resident #52's record and said she focused on the risks and benefits of the side rails but not on the safety assessment.</p> | F 700 | | | |

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| F 880 SS=D | <p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§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:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of</p> | F 880 | | 4/5/19 | |

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| F 880 | <p>Continued From page 24</p> <p>infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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 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, staff interview, and policy review, it was determined the facility failed to ensure standard infection control measures were implemented for 2 of 8 residents (#22 and #24) during observations of blood glucose (BG) checks and medication passes. The failure created the potential for harm if residents</p> | F 880 | <p>F880 Resident Specific Education provided to nurses who provided medication administration for residents #22 and #24 to ensure understanding of facility policy on infection control to include but not limited</p> | | |

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| F 880 | <p>Continued From page 25</p> <p>developed infection from cross contamination when improper hand hygiene techniques were used, a barrier was not utilized under an eye drop container cap, and a contaminated eye drop medication was returned to a medication cart for future use. Findings include:</p> <p>The facility's Hand Hygiene/Handwashing policy, dated 10/1/17, documented handwashing was the "single most important procedure for preventing the spread of infection." The policy documented alcohol-based hand rub (ABHR) may be used for routine decontamination in clinical settings. The policy documented the procedures for handwashing with soap and water, and the use of ABHR as follows:</p> <p>* Soap and water: wet, wash, and rinse, the hands, wrists and exposed portions of the arms, dry with paper towels, then turn off the faucets with a paper towel and discard the paper towel.</p> <p>* ABHR: apply the product to the palm of one hand and rub the hands together, "covering all surfaces of hands and fingers," until the hands are dry.</p> <p>1. On 2/27/19 beginning at 4:45 PM, RN #2 was observed as she prepared a glucometer, Novolog Flexpen (a pre-filled insulin injection pen), 6 oral medications, and a nasal spray for Resident #22. RN #2 took the glucometer and medications to Resident #22's room. She performed the BG check but the glucometer gave an error reading. RN #2 told Resident #22 she was not going to inject the insulin because she needed to get more supplies to re-check the BG. RN #2 administered the oral and nasal medications,</p> | F 880 | <p>to hand hygiene, eye drop administration, and management of contaminated surfaces.</p> <p>Other Residents The clinical management team reviewed infection control practices through random medication pass audits to include eye drop administration and handwashing completed on or before April 5, 2019 by Director of Nurses or designee. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses were educated by Director of Nursing or designee to facility infection control policy including but not limited to hand hygiene, eye drop administration and management of contaminated surfaces.</p> <p>Monitor The Director of Nursing or designee will audit 3 random medication passes for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p> | | |

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| F 880 | <p>Continued From page 26</p> <p>then left the room with the Novolog Flexpen and nasal spray container in her bare left hand.</p> <p>In the hallway, near Resident #22's room, RN #2 dispensed hand sanitizer onto the palm of her right hand. She rubbed the sanitizer over the top of her left hand and fingers and the base of her left hand and used the base of her left hand to spread and rub the sanitizer over her right hand and fingers. She did not rub the hand sanitizer onto the palm of her left hand or in between the fingers of either hand. RN #2 returned to the medication cart, obtained more supplies, then returned to Resident #22's room with the Novolog Flexpen and supplies for the BG measurement.</p> <p>RN #2 rechecked Resident #22's BG and administered the scheduled dose of insulin. She left the room with the glucometer and Novolog Flexpen in her bare left hand. In the hallway, near Resident #22's room, RN #2 dispensed hand sanitizer onto the palm of her right hand and repeated the technique, noted above, to rub the sanitizer on her hands.</p> <p>On 2/27/19 at 4:53 PM, RN #2 said she did not rub hand sanitizer on the palm of her left hand or in between her fingers either time after the BG checks and medication administrations for Resident #22.</p> <p>2. The eye drop administration policy, dated 10/07, documented the administration of eye drops included safe administration. The procedure for administration included removing the eye drop container cap, taking care to avoid touching the dropper tip, and place the cap on a clean, dry surface (such as a tissue or gauze),</p> | F 880 | | | |

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| F 880 | <p>Continued From page 27</p> <p>administer the medication, then replace the cap and return the medication to the medication cart for storage.</p> <p>On 2/28/19 at 11:25 AM, LPN #2 was observed as she prepared Pilocarpine eye drops for Resident #24. In Resident #24's room, LPN #2 removed the cap from the eye drops and placed it on the over bed table without utilizing a barrier under the cap. As LPN #2 administered the eye drops, the cap rolled off the over bed table and fell on the floor by the bed. LPN #2 picked up the cap and began putting it on the eye drop container. LPN #2 was stopped prior to replacing the contaminated cap and she was asked about the contaminated cap and eye drop container. LPN #2 said she was going to clean them. LPN #2 then went into Resident #24's restroom, washed her hands and the eye drop container cap with soap and water. She turned off the faucet with her bare hand, then dried her hands and the cap with paper towels. At that point, she was asked about the bare hand contact with the faucet and if soap and water was sufficient to sanitize the eye drop container cap. LPN #2 said she was going to rewash her hands, which she did, using proper technique. After that, LPN #2 took the eye drop container and cap to the medication cart, wiped both of them with alcohol wipes, put the cap back on Resident #24's eye drop container and put the container in the medication cart for future use.</p> <p>On 2/28/19 at 2:30 PM, the DNS said she expected nurses to discard contaminated eye drop containers/lids. She said washing potentially contaminated containers or caps with soap and water and/or wiping them with alcohol wipes was</p> | F 880 | | | |

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| F 880 | Continued From page 28 not sufficient. She said she was going to discard Resident #24's contaminated eye drops. | F 880 | | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the | F 883 | | 4/5/19 | |

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| F 883 | <p>Continued From page 29</p> <p>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 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 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 policy review, record review, and staff interview, it was determined the facility failed to ensure immunizations were offered to residents on admission. This was true of 1 of 5 residents (Resident #35) reviewed for immunizations. This failure created the potential for harm to residents should they acquire, transmit, or experience complications from influenza and pneumococcal disease. Findings include:</p> <p>The facility's Pneumococcal and Influenza vaccine policy and procedure, dated 10/31/17, directed staff to reduce the risk of infection and transmission of pneumococcal and influenza by offering the vaccines to the residents and education regarding the benefits of immunizations.</p> | F 883 | <p>F883 Resident Specific The clinical management team reviewed resident #35 to ensure facility had received the appropriate immunization records from community physician and/or provided immunization as indicated.</p> <p>Other Residents The clinical management team reviewed all other residents to ensure appropriate immunization records were on file with the facility and/or provided immunization as indicated. Adjustments have been made as indicated.</p> <p>Facility Systems</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 883 | Continued From page 30 Resident #35 was admitted to the facility on 1/3/19, with multiple diagnoses including dementia, transient cerebral ischemic attack (stroke), diabetes mellitus type 2, generalized muscle weakness and dysphagia (difficulty swallowing). Resident #35's admission MDS assessment, dated 1/10/19, documented he was cognitively intact, he did not receive the Influenza vaccine and he was not up-to-date for the Pneumococcal vaccine. Resident #35's record did not include a consents or education for the Influenza and Pneumococcal vaccines. On 2/27/19 at 1:30 PM, the Clinical Resource Nurse stated the facility did not have documentation related to Resident #35's immunization status. The Clinical Resource Nurse stated the immunization status should have been determined on admission. At 2/28/19 at 9:55 AM, UM #1 stated Resident #35's immunization status was missed and she did not know why his immunization status was not completed. On 3/1/19 at 8:30 AM, Resident #35 stated he did not remember the facility discussing his immunization status on admission. | F 883 | Licensed nurses were educated by Director of Nursing or designee to immunization policy to include but not limited to checking history of immunizations, develop immunization plan based on response, and provide immunizations as indicated. The system is amended to include clinical management team to review in clinical meeting immunization records/administration for new admissions, as well as residents scheduled for care conferences. Monitor The Director of Nursing or designee will audit all new admissions and residents with care conferences for appropriate immunization records for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Compliance 4/5/2019 | | |



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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July 26, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **February 25, 2019** through **March 1, 2019**, an unannounced on-site complaint survey was conducted at Wellspring Health & Rehabilitation Of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008044

ALLEGATION #1:

Resident call lights were not answered in a timely manner.

FINDINGS #1:

During the investigation, residents were observed, staff, residents and residents' family were interviewed, and resident records, grievances, and Resident Council minutes were reviewed.

During the survey, resident call lights were observed in the morning, during the day, and in the evenings on each hall of the facility. Staff response to call lights was observed to be timely.

The facility's grievance file was reviewed. The file had no grievances related to call light response time from 12/1/18 through 2/25/19. The Resident Council minutes were also reviewed. There were six documented incidents related to call light issues for each month from 11/12/18 through 1/21/19 and a follow up from the facility was initiated for each incident.

Fifteen residents and three resident family members were interviewed for call light response times and

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there were no concerns voiced related to call light response times.

During the Resident Council Meeting, four residents in attendance stated call light response times have improved in the past three months. The residents stated the call light issues were random. The Council said during mealtimes there was some delay in call lights being answered due to many residents eating in their room.

During an interview with the Administrator, she stated the facility completed an audit in December 2018 after the call light issues were brought to the facility's attention. The Administrator stated the audit did not show call lights were a consistent problem and there were some delays in call lights being answered during mealtimes due to the number of residents eating in their room. The Administrator stated the facility was going to continue to meet with the residents monthly, beginning in February 2019, to make sure there were no issues with call lights not being answered in a timely manner. The Administrator provided the documentation related to the audits and plans for meeting with residents monthly.

Based on the investigative findings, the allegation was substantiated. However, no citation was issued due to the facility's current corrective action of auditing call light response time and plan to meet with residents monthly for feedback to improve call light response time.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

Residents' skin breakdown was not addressed by the facility.

FINDINGS #2:

During the investigation, residents were observed, staff, residents and residents' family were interviewed, the facility's pressure ulcer and skin alterations policy was reviewed, and resident records were reviewed.

Review of the facility's Prevention and Treatment of Pressure Ulcers and Other Skin Alterations policy and procedure dated 11/28/17, documented the facility had a system in place to provide skin integrity, prevent ulcer development/other skin alterations, promote healing of existing wounds consistent with professional standards of practice and prevent further development of additional skin alterations unless the individual's clinical condition demonstrates they were unavoidable.

Ten resident records were reviewed. The records had no documentation related to skin issues from 12/1/18 through 2/25/19.

One resident admitted in January 2019, had a physician order for barrier cream to be applied to the resident's skin with incontinence care every morning and at bedtime for history of a rash. The resident's care plan included documentation to address the resident's skin related issues.

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The resident's Weekly Skin Checks, documented the resident's skin issues were addressed on admission and had healed. The resident's Treatment Administration record documented the resident was to be provided wound care from 1/3/19 to 1/31/19. The resident's care conference documentation included the resident's family had a concern about the resident's skin care and the facility addressed the concern on 1/24/19.

A review of a second resident's record included physician orders to apply foam (a soft absorbent pad) to the resident's heel and wrap with it Kerlix (a cotton dressing) to protect the skin. The orders also included the facility was to provide Prevelon boots (a type of boot to protect heels from developing pressure sores) to both lower extremities while in bed for protection. The orders also directed staff to provide wound care, evaluation, and treatment. The resident's

Progress Notes documented the resident was provided wound care from 2/1/19 through 2/25/19. The resident's Care Plan, documented wound care was initiated. The resident's Weekly Skin Checks, documented the pressure ulcer had improved from 11/19/18 through 2/26/19. In an interview, the resident stated they did not have concerns related to skin care provided by the facility.

Fifteen residents and three resident family members were interviewed and stated there were no concerns with skin related issues.

During an interview, the Wound Care Nurse stated she assessed and managed all skin related issues and provided pressure ulcer cares. The Wound Care Nurse stated she worked with a Physician Assistant two days a week and with floor nurses who provided daily dressing changes.

One resident was observed receiving wound care by the Wound Care Nurse to three sites on his left foot and ankle. There were no issues or concerns observed with the wound care provided to the resident. In an interview, the resident stated he was very satisfied with the care provided by the facility.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Resident diet changes were made without reason and a resident was secluded from other residents during meals.

FINDINGS #3:

During the investigation residents were observed, records were reviewed, and staff, residents, and residents' families were interviewed.

Resident rooms were observed during meals, and two dining rooms were observed during breakfast, lunch and dinner. There were no observations of related diet issues or concerns related to residents being isolated.

Review of one resident's record, documented he was admitted in January 2019 with a diagnosis of dysphagia (difficulty swallowing). The Speech Language Pathologist (SLP) progress notes documented the resident was monitored by the SLP during meals as his diet progressed from pureed foods to mechanical soft foods, and finally to a regular diet. The resident then attended his meals in the dining room with other residents when he no longer needed monitoring by the SLP. The resident's care conference on 1/24/19, documented the resident's family had a concern with his diet and the facility discussed with the family he was on a mechanical soft diet and the facility was working on moving him to the main dining room.

Fifteen residents and three resident family members were interviewed and stated there were no related diet issues or concerns related to residents being isolated during meal times.

During the Resident Council Meeting, four residents in attendance stated there were no issues related to their diet being changed without notice or concerns about residents being isolated during meal times.

In an interview with the Diet Manager and Dietitian, they stated on admission the manager met with residents and residents' family and determined their diet needs. Any residents with specific diet needs were assessed by the SLP. The SLP submitted a form to the Diet Manager requesting a specific diet. The manager stated they had a weekly meeting to review meals for residents at risk for adequate nutrition.

During an interview, the SLP stated residents were assessed and evaluated for diets. Diets were recommended and submitted to the Diet Manager. The SLP stated while working with a resident, the resident was informed of the required diet. The SLP stated residents' diets were not changed without resident or resident family notification.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Resident laundry was missing, despite clothing being labeled.

FINDINGS #4:

During the investigation staff, residents, and residents' families were interviewed and resident records, grievances and Resident Council minutes were reviewed.

Grievance records included documentation there were three incidents of missing clothing items for one resident. The clothing items were found or replaced by the facility. The Resident Council Minutes from 8/10/19 to 1/21/19 did not document concerns related to laundry.

One resident's record, included a care conference note which documented the resident's family had a concern with his missing clothing and the resident's family completed an inventory list. In an interview with the resident, he stated he did not have concerns about his laundry provided by the facility.

Fifteen residents and three resident family members were interviewed and stated when they had missing clothing, they completed a grievance form and the clothes were either found or replaced by the facility.

During the Resident Council Meeting, four residents in attendance stated when they had missing clothing, they completed a grievance form and the clothes were either found or replaced by the facility.

In an interview, the Housekeeping Aide stated the process for residents missing clothes was to find any missing clothing items and if they cannot be found, the resident submitted a grievance form with the assistance of the Licensed Social Worker. The Housekeeping Aide stated currently there was no missing clothing.

In an interview, the Licensed Social Worker and the Unit Manager stated they were not aware of any missing clothing items. They stated when there were missing items, a grievance form was submitted by the Licensed Social Worker and the items were found or replaced.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility does not respond to phone calls from families with concerns.

FINDINGS #5:

During the investigation, resident records were reviewed, and staff, residents and residents' families were interviewed.

One resident's record included a progress note which documented the resident's family was notified by phone the resident's feeding tube was removed. The note also documented the resident's family was notified the resident was seen by the physician, new orders were implemented, a referral was submitted to have his feeding tube removed, and the resident was taking foods orally. The note further documented, the resident's family requested a consult with the Primary Care Provider related to the resident's care.

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The Unit Manager stated in an interview the facility had addressed the family's concerns, spoke with them weekly, and no concerns were currently being voiced.

In an interview, the resident stated he did not have concerns related to his care provided by the facility.

Fifteen residents and three resident family members were interviewed and stated they did not have concerns with the facility not addressing their concerns or returning their phone calls.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

LT/lj



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August 9, 2019

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

Provider #: 135094

Dear Ms.. Mills:

On **March 1, 2019**, an unannounced on-site complaint survey was conducted at Wellspring Health & Rehabilitation of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007995

ALLEGATION #1:

The facility took over residents' finances.

FINDINGS #1:

An unannounced recertification and complaint survey was conducted from 2/25/19 to 3/1/19. During the survey, resident records were reviewed and staff and residents were interviewed. Fifteen residents' records were reviewed for personal fund concerns. There was no documentation in the records of concerns regarding personal funds.

Eight of the fifteen residents were interviewed regarding personal finances. Eight residents stated they either have a trust with the facility and received quarterly statements or their representative takes care of the finances for them. The eight residents stated they were able to receive their money when they requested it.

Seven of the fifteen residents were appointed a guardian and stated they had no concerns with

getting their money when needed.

During the review of records one resident, admitted March 2017, had a guardian and a trust fund with the facility. The resident's record documented quarterly statements to the guardian. The guardian for the resident stated they receive quarterly statements from the facility. The guardian stated if the resident needed money and the resident did not have enough money in the trust account fund, the guardian would assist in providing the funds for the resident.

The Resident Services Representative stated she had spoken to the resident's family member regarding Power of Attorney and the family did not fill out the paperwork and the resident needed a guardian to be represented for healthcare and finances.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are not being seen by the physician in the facility.

FINDINGS #2:

During the survey, resident records were reviewed and a physician was interviewed.

One of the fifteen resident's records documented the resident was regularly seen by a physician or a nurse practitioner, who assessed and evaluated changes of condition. Fourteen other residents records were reviewed for physician services and no concerns were identified.

The resident's physician stated he came to the facility weekly and reviewed his residents records, and physically met with residents every other month. The physician stated his nurse practitioner saw the residents monthly, or as needed.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents acquired upper and lower contractures in the facility after admission.

FINDINGS #3:

During the survey, resident records were reviewed and staff were interviewed.

Six resident records were reviewed for contractures. One resident's record was reviewed and documented upon admission the resident had impairments to both upper and lower extremities. The discharge diagnoses from the hospital, in March 2017, documented the resident was debilitated and deconditioned.

The Unit Manager and the Director of Rehabilitation stated the resident was admitted with contractures to both upper and lower extremities. The Director of Rehabilitation stated the resident was receiving therapy for positioning and passive range of motion due to severe deconditioning and rigidity.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION 4:

Residents were not receiving wheelchairs after rehabilitation services were provided.

FINDINGS #4:

During the survey, resident records were reviewed, residents were interviewed, and staff were interviewed.

Three residents were interviewed regarding assessments for wheelchairs by the rehabilitation department. Two residents had no concerns with receiving rehabilitation services and were fitted for wheelchairs.

Three resident records were reviewed for assessments of wheelchair positioning. One resident's record documented the resident was assessed for postural alignment and skin integrity in various reclining high back wheelchairs including consultation with an adaptive technology specialist with no viable seating system determined due to severity of contractures and rigidity.

The Director of Rehabilitation stated the resident was admitted with debilitation and deconditioning. The Director of Rehabilitation stated the resident did receive therapy for range of motion and

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positioning and it was determined the resident was unable to tolerate being in the wheelchair.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents acquired pressure ulcers in the facility and became infected without treatment.

FINDINGS #5:

During the survey, resident records were reviewed for pressure ulcers and treatment.

Three resident records were reviewed for pressure ulcers and treatment. One of the three resident's records documented the resident had a pressure ulcer to the resident's heel and was diagnosed as osteomyelitis (an infection of the bone). The resident's record documented the resident received intravenous antibiotics in the facility and the pressure ulcer was healed after antibiotic treatment and wound care treatment.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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
LT/slj