IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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July 17, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **July 12, 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 29 2019**. Failure to submit an acceptable PoC by **July 29, 2019**, may result in the imposition of penalties by **August 19, 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 <u>in column (X5)</u>.

  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 **August 16, 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 **October 12, 2019**. A change in the seriousness of the deficiencies on **August 26, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 12, 2019** includes the following:

Denial of payment for new admissions effective **October 12, 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 **January 12, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **October 12, 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:

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:

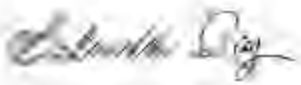
- BFS Letters (06/30/11)

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

This request must be received by **July 29, 2019**. If your request for informal dispute resolution is received after **July 29, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135094		C 07/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRING HEALTH & REHABILITATION OF CASCADIA	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 complaint survey of the facility. The survey team entered the facility on July 11, 2019 and exited the facility on July 12, 2019. The surveyors were: Jenny Walker, RN, Team Coordinator Laura Thompson, RN Acronyms used in the report include the following: ER - Emergency Room LN - Licensed Nurse	F 000		
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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents were closely monitored for a change in condition and it was documented in their record for 1 of 3 residents (Resident #2) reviewed for standards of practice. This failed practice had the potential for residents to experience a further	F 684	This plan of correction is submitted as required under Federal and State regulations and statues applicable to long-term care providers. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the	7/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2019

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 684	Continued From page 1 decline in health due to lack of monitoring and assessment. Findings include: Resident #2 was admitted to the facility on 4/5/19 and readmitted on 7/11/19, with multiple diagnoses including cerebral palsy. A Nurse's Progress Note, dated 7/3/19 at 2:32 PM, documented Resident #2 required increased tracheostomy suctioning with green mucous production, had a strong urine odor, and required additional treatment by the Respiratory Therapist. A Nurse's Progress Note, dated 7/3/19 at 4:10 PM, documented the physician was notified of the change of condition for Resident #2. Physician orders were received for blood work, a chest x-ray, a urine sample, and to start antibiotics. The progress notes documented the blood work was obtained and sent to the laboratory. The LN was unable to obtain a urine sample after several attempts and the bedside x-ray was to be completed that evening. There was no documentation by nusing staff of Resident #2's condition or status on 7/4/19 and 7/5/19. A Nurse's Progress Note, dated 7/6/19 at 10:36 PM, documented Resident #2's respiratory status declined and she had an elevated heart rate. The progress note documented physician orders were received to send Resident #2 to a local ER for further evaluation. Resident #2 was admitted to the hospital on 7/6/19 and discharged back to the facility on 7/11/19, with respiratory failure and a urinary tract infection.	F 684	scope and severity of the deficiencies cited are correct applied. F-684 1. Specific issue: Due to Resident #2 being discharged to the hospital, alert charting on her could not be rectified. 2. Other residents: Residents on antibiotic therapy or with change of condition have been evaluated and their notes reviewed. Adjustments have been made as indicated. 3. Systemic Changes: Licensed nurses are educated to documentation for resident change of condition. Re-education was provided by the Director of Nursing Services and/or designee to include but not limited to alert charting for antibiotic use, documentation for residents with change in condition, and the resident monitoring process. The system reviews change of condition in clinical meeting and is amended to include weekend and holiday review by nurse leadership. 4. Monitor: The DNS and/or designee will audit resident records for documentation of change of condition, to include antibiotic use for 3 residents weekly for 8 weeks. Starting the week of July 28, 2019, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed	

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F 684	Continued From page 2 On 7/12/19 at 2:55 PM, Unit Manager #1 stated the facility had a system to alert licensed nurses to complete documentation each shift when a resident had a change in status or medical condition in the E-MAR (electronic medication administration record). Unit Manager #1 stated the system listed the residents who required documentation of their change of condition on each shift for 3 days. Unit Manager #1 stated when residents had a change of condition, started a new medication, or had abnormal blood work results, the nurse's documented in the progress notes the health status of the resident. On 7/12/19 at 3:05 PM, Unit Manager #2 stated he worked as a floor nurse on 7/4/19 and was assigned as Resident #2's nurse. Unit Manager #2 stated Resident #2 was receiving antibiotics for a change in her respiratory status and a possible urinary tract infection. Unit Manager #2 reviewed Resident #2's nursing progress notes and stated Resident #2's record did not include documentation of Resident #2's change in health status condition from the night shift on 7/3/19 to the evening shift on 7/6/19. He stated when the evening shift nurse documented Resident #2 was sent to the ER for further evaluation it was 3 days later. Unit Manager #2 stated the nurse's should have documented on Resident #2's health status every shift from 7/3/19 to 7/6/19.	F 684	with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.	

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July 19, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **July 12, 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 #ID00008177

ALLEGATION #1:

Residents who required ventilators were not supervised and treated appropriately.

FINDINGS #1:

An unannounced complaint survey was conducted from 7/11/19 to 7/12/19. During the survey three resident records were reviewed, observations were conducted, facility incident reports were reviewed and staff were interviewed.

Observations were conducted during the night shift for care and services on the respiratory unit. Twelve residents resided in the unit and seven of the residents required the use of a ventilator (a machine that supports breathing). Two Respiratory Therapists (RT) were working the night shift

and were observed providing care to four of the residents. One of the RTs went into a resident's room who was on a ventilator and was observed using a stethoscope to listen to the lungs, she suctioned the resident's respiratory tube, checked the settings on the ventilator, and provided oral care. The RT stated she does this a minimum of every four hours for the resident, or more frequently if needed.

The second RT stated the therapists work 12 hours and there were two therapists assigned and working in the unit on day shift and night shift. He stated during the day there was also the Director of Respiratory and another RT who floated to assist residents when they were transported to and from appointments. Both RTs stated there were alarm systems for the ventilators and the monitors on residents. The monitors on residents were used for measuring a resident's heart rate and oxygen saturation.

During the review of records one resident, admitted December 2016, was ventilator dependent at all times. An incident report documented the resident's ventilator alarm was sounding and one RT responded within minutes to troubleshoot the problem. The incident report stated the ventilator tubing was disconnected and the RT reconnected the tubing to the ventilator and the alarm continued to sound. The report stated the RT found the pulse oximetry connection, which was on the resident's toe, was not picking up the resident's oxygen saturation and heart rate. The incident report stated the RT adjusted the monitor and it was connected. The report stated a second RT entered the room with a nurse, while the first RT was assessing the resident's airway. When the first RT was unable to find a pulse, the second RT announced a code and they began CPR. The nurse called 911 and gathered the paperwork for the paramedics, while the two RTs were performing CPR until the paramedics arrived. The paramedics were able to assess a pulse and the resident was taken to the hospital.

The Director of Respiratory, the two RT's, and the nurse were interviewed on 7/12/19. The two RT's identified in the incident report were interviewed separately regarding the resident who coded. One of the RTs stated on the day of the event with the resident six staff members were in her room assisting with personal cares. After the cares were completed the RT stated they went to another resident's room to provide respiratory care. The RT stated when they came out of the room an external alarm was sounding at the above identified resident's room. The RT stated they went into the room and discovered the ventilator tube was disconnected at the level of the machine and they reconnected the tubing. The RT stated they noticed the pulse oximeter was continuing to alarm and it was assessed it was not picking up any readings and it was readjusted by the RT. The RT stated at that point the second RT came in the room with the nurse, and while assessing the resident they were unable to find a pulse and they initiated CPR while the nurse called 911. The second RT was also interviewed and stated they were also assisting with personal cares of the resident prior to the event. The RT stated after personal cares were completed they went to another resident's room to provide respiratory care. The second RT stated the nurse informed them the alarm for the pulse oximeter was sounding and both went to

the resident's room to assess and the first RT was in the room. The second RT stated they looked at their watch when they left the resident's room after the personal cares and when they went back and five minutes had elapsed.

The Director of Respiratory stated the resident rooms have external alarms just outside the room door which are audible as well as visual. She stated the ventilators also have audible and visual alarms. The Director of Respiratory stated she is responsible for training all staff who perform patient care on the respiratory unit. She stated she does a classroom presentation with a PowerPoint, which was reviewed, and then assesses the competency of staff with the new skills prior to them working on the floor. The Director of Respiratory stated she does ongoing audits and education of respiratory competencies of staff.

It could not be established the facility failed to respond to a resident's ventilator alarm timely and appropriately. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility's staff did not notify resident's emergency contact of their change in condition.

FINDINGS #2:

Three out of three residents' records were reviewed for a change in condition and the family or emergency contact were informed. Two of the three residents' families or emergency contacts were notified of the resident's change of condition at the time.

One of the three resident's records documented an emergency contact person. The person was not notified per documentation from social services that the emergency contact person did not want to be involved or notified with the resident's care. The resident's record documented the resident did not want anyone to be contacted on her behalf of a change in condition.

The allegation was unsubstantiated due to lack of evidence regarding residents' families or emergency contact not being notified of the resident's change of condition.

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