



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
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December 2, 2019

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

Provider #: 135094

Dear Ms. Mills:

On **November 15, 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.

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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 **December 12, 2019**. Failure to submit an acceptable PoC by **December 12, 2019**, may result in the imposition of penalties by **January 4, 2020**.

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 **December 20, 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 **February 13, 2020**. A change in the seriousness of the deficiencies on **December 30, 2019**, may

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result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 15, 2020** includes the following:

Denial of payment for new admissions effective **February 15, 2020**. [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 **May 15, 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 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 **February 15, 2020** 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:

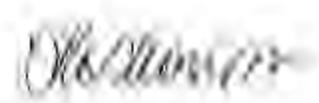
- BFS Letters (06/30/11)

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

This request must be received by **December 12, 2019**. If your request for informal dispute resolution is received after **December 12, 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,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/dr

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

PRINTED: 12/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2019
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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted from November 12, 2019 to November 15, 2019. The surveyors conducting the survey were: Presie Billington, RN, Team Coordinator Brad Perry, LSW Kim Saccomando, RN Deborah Abasciano, RN Abbreviations: ADL = Activity of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram RN = Registered Nurse RT = Respiratory Therapist UM = Unit Manager	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		12/18/19	

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

TITLE

(X6) DATE

Electronically Signed

12/09/2019

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 550	<p>Continued From page 1</p> <p>promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, guardian and staff interview, it was determined the facility failed to respect a resident's dignity and individuality when staff did not dress the resident in her personal clothing. This was true for 1 of 15 residents (Resident #39) who were reviewed for dignity. This created the potential for</p>	F 550	<p>F550 Resident Specific Resident #39's personal preferences and care plan were reviewed by clinical management team and care plan was updated to include preference of resident/resident's guardian to wear</p>		

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F 550	<p>Continued From page 2</p> <p>psychosocial harm if a resident experienced embarrassment or a lack of self-esteem due to being observed in a hospital gown. Findings include:</p> <p>The facilities Quality of Life policy, dated 11/28/17, documented the residents had the right, were encouraged, and assisted to dress in their own clothes appropriate to individual preferences rather than a hospital-type gown.</p> <p>This policy was not followed.</p> <p>Resident #39 was admitted to the facility on 4/5/19, with multiple diagnoses including cerebral palsy (a group of disorders that affect movement, muscle tone or posture due to immature brain development), chronic respiratory failure, and seizures.</p> <p>On 11/12/19 at 10:40 AM, 1:45 PM, and 2:44 PM, Resident #39 was observed to be awake in her room in bed in a hospital-type gown.</p> <p>On 11/13/19 at 9:30 AM, Resident #39's guardian stated she was frustrated because Resident #39 was not in her personal pajama's.</p> <p>On 11/13/19 at 9:42 PM, Resident #39's guardian stated Resident #39 had personal clothes to wear but she had never seen Resident #39 wear them. Resident #39's guardian stated she visited Resident #39 at the facility 1-2 times a week. Resident #39's guardian stated when she asked a staff member why Resident #39 was not wearing her personal clothes, the staff member replied by asking Resident #39's guardian if she knew how hard it was to get Resident #39</p>	F 550	<p>personal clothes/pajama instead of hospital gown.</p> <p>Other Residents Residents were observed to validate that residents not wearing personal clothing were offered personal clothing options. Care plans were updated according to the resident's preferences.</p> <p>Facility Systems Nursing staff were educated by Director of Nurses and/or designee on or before December 13, 2019 regarding facility policy on Quality of Life, to include but not limited to the right for residents to dress in their own clothes and pajama's appropriate to individual preferences. The system is amended to include routine observation rounds of residents to validate preferred clothing is offered and available.</p> <p>Monitor The Director of Nurses and/or designee will round twice weekly and observe for residents not in personal clothing. These resident care plans will be reviewed/revise and staff educated on dressing residents in personal clothing as indicated for 3 months. 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</p>		

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

PRINTED: 12/16/2019
FORM APPROVED
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F 550	Continued From page 3 dressed. Resident #39's guardian stated she took Resident #39's clothes home and altered them to make them easier to put on. Resident #39's guardian stated she took the clothes back to the facility but had never seen Resident #39 wear her personal clothing. On 11/14/19 at 8:08 AM, 8:49 AM, 9:19 AM, and 10:45 AM, Resident #39 was observed to awake in her room in bed in a hospital-type gown. On 11/14/19 at 3:40 PM, CNA #9 stated Resident #39 had a closet full of clothes. CNA #9 stated they tried to dress Resident #39 in her own clothes and sometimes would use a hospital-type gown. On 11/14/19 at 3:57 PM, CNA #10 stated Resident #39 had a lot of clothes and nightgowns, but she sometimes would wear a hospital-type gown. On 11/15/19 at 11:59 AM, UM #2 stated he knew Resident #39 had a lot of clothes the CNAs could choose from when dressing her. He stated his expectation would be that Resident #39 would be dressed in her own clothes. UM #2 stated when CNAs lay Resident #39 down at night, they generally put her in a hospital-type gown.	F 550	12/18/2019		
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	F 657		12/18/19	

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F 657	<p>Continued From page 4 includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</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 record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated. This was true for 2 of 15 residents (#18 and #44) whose care plans were reviewed. This created the potential for harm if cares and/or services were not provided appropriately due to inaccurate information on the care plans. Findings include:</p> <p>The facility's policy and procedure regarding person-centered care plans, dated 11/28/19, documented the care plan would be revised and updated by the interdisciplinary team as necessary to reflect the resident's current status.</p>	F 657	<p>F657 Resident Specific Residents #18 and #44 care plan was reviewed by clinical management team and care plan was updated to by removing orders that had been discontinued and personalizing non-drug interventions for pain management.</p> <p>Other Residents Residents care plans were reviewed by clinical management team on or before December 13, 2019 to address care plans were updated to by removing orders that had been discontinued and personalizing</p>		

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F 657	<p>Continued From page 5</p> <p>This policy was not followed:</p> <p>1. Resident #18 was admitted to the facility on 5/29/19, with multiple diagnoses including anxiety disorder.</p> <p>Resident #18's care plan, initiated on 6/13/19, documented she used anti-anxiety medication related to her anxiety disorder, and to give her anti-anxiety medication as ordered by the physician.</p> <p>Resident #18's November 2019 MAR, documented Lorazepam (anti-anxiety medication) 0.5 mg one tablet by mouth every 24 hours as needed was ordered on 6/29/19 and was discontinued on 11/7/19.</p> <p>On 11/15/19 at 11:00 AM, UM #1 said Resident #18 used to take Lorazepam 0.5 mg as needed but it was discontinued by the physician. UM #1 said the care plan should have been updated when the Lorazepam was discontinued.</p> <p>2. Resident #44 was admitted to the facility on 7/3/19, with multiple diagnoses including unspecified osteoarthritis.</p> <p>A physician's order, dated 7/3/19, documented "encourage non-pharmacological interventions."</p> <p>A quarterly MDS assessment, dated 10/9/19, documented Resident #44 was cognitively intact.</p> <p>Resident #44's care plan, dated 7/4/19, directed staff to give her medications as necessary for breakthrough pain as per physician's orders, implement relaxation techniques to assist with</p>	F 657	<p>non-drug interventions.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses and/or designee on or before December 13, 2019 regarding facility policy to complete revisions to resident care plans, to include but not limited to, removing orders that have been discontinued and personalizing non-drug interventions. The system is amended to include review in clinical meeting residents with order changes and those who receive PRN pain medications validating care plans are updated to include removal of discontinued medication and person-centered non-drug interventions.</p> <p>Monitor The Director of Nurses and/or designee will audit 5 resident care plans with order changes or who receive PRN medications weekly x 4 weeks and then 10 random care plans monthly x 2. 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 12/18/19</p>		

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F 657	<p>Continued From page 6 pain control, and to listen to her concerns.</p> <p>On 11/12/19, at 1:41 PM, Resident #44 said she had right shoulder pain with movement since yesterday and the pain medication was not working. When Resident #44 was asked what her pain level was on the scale of 1 to 10. Resident #44 said her pain level was an 8. Resident #44 said she told the nurse an ice pack made her pain worse and a hot pack usually helped. Resident #44 said RN #2 told her she was only able to give her a warm towel. Resident #44 said the nurse gave her a hot towel for 20 minutes during the day shift and her pain decreased to a level of 5. Resident #44 said the nurses on the other shifts did not ask her if she wanted a warm towel to her right shoulder when she reported pain.</p> <p>A late entry Nurse's Note, dated 11/15/19 at 10:31 AM, documented Resident #44 had ineffective pain relief from Oxycodone and refused ice. The Nurse's Note documented Resident #44 requested a warm towel, which was applied for 20 minutes with pain relief. The Nurse's Note also documented Resident #44 received a second warm towel, which she stated was helpful.</p> <p>On 11/15/19, at 11:04 AM, RN #2 said Resident #44 told her heat helped with the pain. RN #2 said on 11/12/19 and 11/13/19, during the day shift, she placed warm water on a towel, placed the towel in a bag wrapped the bag in a pillow case and placed it on Resident #44's right shoulder for 20 minutes. RN #2 said Resident #44 told her the pain was better. RN #2 said she did not revise Resident #44's care plan with the</p>	F 657			

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F 657	Continued From page 7 new intervention but should have since it was effective.	F 657			
F 679 SS=D	On 11/15/19 at 4:15 PM, the DON said RN #2 did not revise Resident #44's care plan to include the warm towel to her right shoulder for pain. Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review, activity calendar review, and resident representative and staff interview it was determined the facility failed to ensure a resident was provided with activities that met the individual needs of 1 of 3 residents (Resident #39) reviewed for activities. This failure created the potential for residents to experience boredom and a lack of stimulation. Findings include: The facility's activity policy, dated 11/28/17, directed staff to: * Follow the comprehensive assessment, care plan and individual preferences of each resident regarding activities. * Assist residents to activities and assist in	F 679	F 679 Resident Specific Resident #39's activity assessment and care plan were reviewed for preferred activities and tasks assigned to staff to provide TV/music as indicated when resident is in her room, and escort her to reading group. Other Residents Residents dependent on staff for ADL's, unable to communicate or make their needs known had their activity assessments and care plans reviewed and updated for preferred activities. Tasks are assigned to staff to provide activities	12/18/19	

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F 679	<p>Continued From page 8 participating in desired activities. * Assist residents in activities that are emotionally soothing, such as listening to music. * Assist in transportation of residents to the activity location.</p> <p>This policy was not followed.</p> <p>Resident #39 was admitted to the facility on 4/5/19, with multiple diagnoses including chronic respiratory failure and cerebral palsy.</p> <p>Resident #39's admission MDS assessment, dated 4/12/19, documented music was important to the her. The MDS documented she was totally dependent on staff for all activities.</p> <p>Resident #39's activities admission assessment, dated 4/20/19, documented she preferred music and watching television (TV). The assessment documented she was unable to communicate, unable to make her needs known, and was dependent on staff for all activities of daily living.</p> <p>Resident #39's care plan directed staff to offer in room activities of television and music and to bring her to the activity office when there was a reading group.</p> <p>Facility Activity Calendar for October and November 2019 documented a reading group activity every Sunday at 2:00 PM.</p> <p>Resident #39's October and November 2019 activity record documented she did not participate in the reading group activity. There was no documentation in her record she was offered to attend the reading group activity.</p>	F 679	<p>as indicated.</p> <p>Facility Systems Nursing, social services, and activity staff were educated by Executive Director and/or designee on or before December 13, 2019 regarding facility's activity policy, to include but not limited to, following the comprehensive assessment, care plan and individual preferences of each resident regarding activities; assisting residents to activities and assisting with participation; and assisting in transportation of residents to the activity. The system is amended to include review during clinical rounds to validate dependent residents are engaged in activities of choice. In addition, documentation of preferences will be reviewed periodically.</p> <p>Monitor The Executive Director and/or designee will observe 5 random residents for implementation of individualized activity programming and documentation of participation weekly x 4 then monthly x 2. 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 12/18/2019</p>		

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F 679	<p>Continued From page 9</p> <p>On 11/12/19 at 10:40 AM, 1:45 PM, and 2:44 PM, Resident #39 was observed to be awake in her bed in her room. The TV and radio/CD player were not on.</p> <p>On 11/13/19 at 8:15 AM, 10:50 AM, and 11:07 AM, Resident #39 was observed to be awake in her bed in her room. The TV and radio/CD player were not on.</p> <p>On 11/13/19 at 9:30 AM, Resident #39's guardian stated she was frustrated because whenever she visited Resident #39 she was usually in bed and there was no music or TV on in her room.</p> <p>On 11/13/19 at 9:42 AM Resident #39's conservator stated she had only seen Resident #39 up out of bed one time since April.</p> <p>On 11/13/19 at 1:30 PM, CNA #5 and CNA #6 transferred Resident #39 from her wheelchair to her bed with a mechanical lift. The TV and radio/CD player were not on. After the transfer CNA #5 and CNA #6 left the room and did not turn on the TV or the radio/CD player or offer to turn either one on.</p> <p>On 11/14/19 from 8:08 AM to 8:49 AM, Resident #39 was awake in her bed in her room. The TV and radio/CD player were not on.</p> <p>On 11/14/19 at 8:49 AM, Resident #39 was observed to be awake in her bed in her room. RT #1 performed tracheostomy care on Resident #39 and then left the room without offering to turn on the TV or radio/CD player.</p>	F 679			

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F 679	<p>Continued From page 10</p> <p>On 11/14/19 at 9:19 AM and 10:09 AM, Resident #39 was observed to be awake in her bed in her room. The TV and radio/CD player were not on.</p> <p>On 11/14/19 at 10:45 AM, CNA #7 and CNA #8 were in Resident #39's room assisting her roommate. Resident #39 was awake in her bed. The TV and radio/CD player were not on. After assisting Resident #39's roommate, CNA #7 and CNA #8 left the room without offering to turn on the TV or radio/CD player for Resident #39.</p> <p>On 11/14/19 at 3:40 PM, CNA #9 stated when Resident #39 was awake in her room, staff were to turn her TV or radio on.</p> <p>On 11/14/19 at 3:57 PM, CNA #10 stated when Resident #39 was awake in her room, staff were to turn on her TV.</p> <p>On 11/15/19 at 8:40 AM, Resident #39 was observed to be awake in her bed in her room. The TV and radio/CD player were not on.</p> <p>On 11/15/19 at 12:05 AM, UM #2 stated he was not sure if staff put music on while Resident #39 was in her room. He stated he expected staff to turn on Resident #39's TV or radio when she was awake in her room.</p> <p>On 11/15/19 at 2:52 PM and 4:27 PM, the Activities Director (AD) stated she expected staff to have music or TV on for Resident #39 while she was awake in her room. The AD stated Resident #39 enjoyed being read to and attended reading group activities. The AD did not know if Resident #39 attended the October and November Sunday reading group activity held in</p>	F 679			

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F 679	Continued From page 11	F 679			
F 686 SS=D	<p>the activity room, since it was not documented.</p> <p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, resident and staff interview, it was determined the facility failed to ensure residents received appropriate care to prevent skin breakdown. This was true for 2 of 4 residents (#10 and #39) reviewed for skin breakdown. This failure created the potential for harm if residents developed pressure ulcers and skin breakdown. Findings include:</p> <p>The facility's pressure ulcers prevention and skin alterations policy, dated 11/28/17, documented residents were to receive appropriate pressure redistribution and non-irritating support surfaces. The policy documented staff were to establish interventions to prevent skin breakdown.</p> <p>This policy was not followed.</p>	F 686	<p>F686 Resident Specific The clinical management team reviewed resident's #10 & #39. A skin assessment reveals skin integrity is intact. Observation was consistent with care plan with skin prevention to the heels.</p> <p>Other Residents The clinical management team reviewed other residents for risk of development or worsening of pressure ulcers. Adjustments have been made as indicated.</p> <p>Facility Systems Nursing staff were educated by Director of Nurses and/or designee on or before</p>	12/18/19	

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F 686	<p>Continued From page 12</p> <p>1. Resident #39 was admitted to the facility on 4/5/19, with multiple diagnoses including chronic respiratory failure, cerebral palsy, and a history of pressure ulcers.</p> <p>Resident #39's Braden Risk Assessment Scale (a tool used to assess a resident's risk for developing pressure ulcers), dated 9/25/19, documented she was at moderate risk for developing a pressure ulcer.</p> <p>Resident #39's quarterly MDS assessment, dated 9/27/19, documented she did not have pressure ulcers, she was severely cognitively impaired and was totally dependent on two-person assistance for bed mobility and transfers.</p> <p>Resident #39's care plan, dated 6/25/19 and 7/11/19, directed staff to apply prevalon boots (heel protectors) to both feet for pressure ulcer prevention and to apply pillows on her wheelchair footrest for skin protection when in her wheelchair.</p> <p>On 11/13/19 at 10:34 AM, Resident #39 was observed on her airbed in her room. She had on pink knitted slippers on both feet and no prevalon boots.</p> <p>On 11/13/19 at 1:30 PM, CNA #5 and CNA #6 transferred Resident #39 from her wheelchair, which did not have pillows on the footrest, to her airbed. She had the pink knitted slippers on both feet and no prevalon boots. CNA #5 and CNA #6 did not apply or offer to apply prevalon boots to her feet before leaving the room.</p>	F 686	<p>December 13th 2019 on prevention and management of pressure ulcers, including but not limited to, following care plan developed for residents at risk with implementation at the bedside. The system is amended to include observation of skin at risk residents on clinical and management rounds for skin prevention implementation.</p> <p>Monitor The Director of Nursing and/or designee will audit 5 residents at risk of pressure ulcers and residents with alteration in skin integrity weekly for 4 weeks, then twice monthly x 2 months. 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 12/18/2019</p>		

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F 686	<p>Continued From page 13</p> <p>On 11/14/19 at 8:08 AM, 8:49 AM, and 9:19 AM, Resident #39 was in her airbed and had the pink knitted slippers on both feet and no prevalon boots.</p> <p>On 11/14/19 at 10:45 AM, Resident #39 was in her airbed and had the pink knitted slippers on both feet and no prevalon boots. CNA #7 and CNA #8 were in Resident #39's room and did not apply or offer to apply prevalon boots to her feet before leaving the room.</p> <p>On 11/14/19 from 11:47 AM to 12:20 PM and at 2:10 PM, Resident #39 was in her wheelchair watching a movie at the nurse's station. She had the pink knitted slippers on both feet and no prevalon boots. There was no pillow on the wheelchair's metal platform footrest. Throughout these times, Resident #39 rubbed both feet on the footrest, her right foot also rubbed against the side metal bar of the footrest.</p> <p>On 11/14/19 at 3:40 PM, Resident #39 was in her airbed with the pink knitted slippers on both feet and no prevalon boots. CNA #9 said Resident #39 "sometimes" wore small prevalon boots. CNA #9 said she did not have the boots on at that time. CNA #9 said the prevalon boots were kept in the resident's closet. CNA #9 then searched the closet and said she could not find the prevalon boots. CNA #9 said the boots might be in the laundry. CNA #9 said due to Resident #39's sensitive skin, staff applied pillows on her wheelchair footrest.</p> <p>On 11/14/19 at 3:57 PM, CNA #10 said Resident #39 wore prevalon boots when in her wheelchair. CNA #10 said staff were to apply a pillow behind</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>her legs when she was in her wheelchair.</p> <p>On 11/15/19 at 8:40 AM, Resident #39 was in her airbed with her feet touching the mattress. She did not have prevalon boots or slippers on.</p> <p>On 11/15/19 at 9:03 AM, the Wound Nurse (WN) said Resident #39 was admitted to the facility with a wound to the outer side of her left foot that had healed in the facility. The WN said Resident #39's heels dug into her bed and she had preventative dressings on her heels and wore prevalon boots. The WN said sometimes the boots were in the laundry. The WN said Resident #39's pillows would fall off her wheelchair and had thought about placing lamb's wool to line the wheelchair footrest.</p> <p>On 11/15/19 at 11:32 AM, Laundry Aide #1 said after prevalon boots were laundered, they were placed in the 200-hallway clean linen room.</p> <p>On 11/15/19 at 11:35 AM, multiple pairs of prevalon boots were in the 200-hallway clean linen room.</p> <p>On 11/15/19 at 11:49 AM, Resident #39 was in her wheelchair watching a movie at the nurse's station. She had the pink knitted slippers on both feet and no prevalon boots. There was no pillow on the wheelchair's metal platform foot.</p> <p>On 11/15/19 at 12:10 PM, UM #2 said he expected staff to follow Resident #39's care plan and apply the prevalon boots to her feet and place a pillow to her wheelchair footrest. He viewed Resident #39's pink knitted slippers while she was in her wheelchair and without a pillow to</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>the footrest. UM #2 said she did not have on prealon boots. He said there should have also been a pillow on the footrest.</p> <p>On 11/15/19 at 3:35 PM, WN was observed to remove Resident #39's heel protective dressings. Both of her feet and heels were blanchable and did not show signs of skin breakdown.</p> <p>2. Resident #10 was admitted to the facility on 1/28/15 and was readmitted on 6/17/19 with multiple diagnoses, including aphasia (a language disorder that affects a person's ability to communicate) following cerebral infarction (the lack of blood flow resulted in severe damage (to some of the brain tissue).</p> <p>Resident #10's annual MDS assessment, dated 7/15/19, documented she was at risk for developing pressure ulcer.</p> <p>A physician's order, dated 1/17/19, documented "float heels while in bed every shift."</p> <p>Resident #10's skin care plan, revised on 10/10/19, directed staff to float her heels as she would allow.</p> <p>On 11/13/19 at 10:35 AM, Resident #10 was observed in bed. Resident #10's heels were not floated.</p> <p>On 11/14/19 at 2:26 PM, Resident #10 was observed in bed. Resident #10's heels were not floated. Resident #10 said she would have floated her heels if she was asked to.</p> <p>On 11/14/19 at 2:28 PM, LPN #3 asked Resident</p>	F 686			

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F 686	Continued From page 16 #10 if she could place a pillow under her heels. Resident #10 said "Yes." LPN #3 said the CNA could have forgotten to put a pillow under Resident #10's heels when she was put to bed.	F 686			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure effective pain management was provided for 1 of 4 residents (Resident #44), reviewed for pain. This failure created the potential for harm should residents not receive effective pain management. Findings include: The Facility's Pain Management policy, dated 11/28/17, directed staff to notify the physician if interventions were ineffective. Resident #44 was admitted to the facility on 7/3/19, with multiple diagnoses including unspecified osteoarthritis and muscle weakness. Resident #44's physician order, dated 7/3/19, directed staff to encourage non-pharmacological interventions and if in effective to use medication, if neither was effective to notify the physician.	F 697	12/18/19		
			F 697 Resident Specific Resident #44 pain care plan was reviewed by the clinical team to update person-centered non-pharmacological interventions. Other Residents Residents triggering for pain, care plans will be reviewed by the clinical team to address person-centered non-pharmacological interventions. Current residents utilizing PRN pain medication are reviewed to validate effectiveness, if not effective non-pharmacological interventions are implemented and the physician was notified as indicated. Facility Systems Nursing staff were educated by Director of Nurses and/or designee on or before		

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F 697	<p>Continued From page 17</p> <p>Resident #44's physician order, dated 9/19/19, directed staff to administer Oxycodone (narcotic pain medication) HCL (hydrochloride) 5 mg by mouth every 6 hours as needed for pain (PRN).</p> <p>Resident #44's November 2019 MAR documented she received Oxycodone 5 mg on 11/12/19 at 9:23 AM for a pain rating of 10 and it was not effective. There was no documentation in Resident #44's record that the physician was notified of the ineffective results.</p> <p>A Nurse's Note, dated 11/12/19 at 10:23 AM, documented Resident #44 used a non-pharmacological intervention and it was effective.</p> <p>On 11/12/19 at 1:41 PM, Resident #44 said she had right shoulder pain since 11/11/19 and her pain medication was not working. She said a hot pack usually helped. Resident #44 said she received a warm towel from RN #2 that morning for her shoulder and it helped decrease her pain to a 5.</p> <p>Resident #44's November 2019 MAR documented she received Oxycodone 5 mg on 11/13/19 at 6:38 AM for a pain rating of 8 and it was not effective. There was no documentation in Resident #44's record that the physician was notified of the ineffective results.</p> <p>On 11/13/19 at 10:03 AM, RN #1 entered Resident #44's room. Resident #44 told RN #1 she had bad right shoulder pain, had received her pain medication a while ago, and was not due for more pain medication yet. Resident #44 then asked for the warm pack.</p>	F 697	<p>December 13th 2019 regarding facility policy pain management, to include but not limited to implementation of person-centered non-pharmacological intervention, proper documentation of interventions preformed, and physician notification when interventions are not affective as indicated. The system is amended to include review in clinical meeting residents with PRN medication use that is not effective to validate non-pharmacological interventions area attempted and the physician is updated for change in plan.</p> <p>Monitor The Director of Nurses and/or designee will audit 5 residents for effective pain management plans weekly x 4 weeks and then monthly x2. 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 12/18/2019</p>		

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F 697	<p>Continued From page 18</p> <p>On 11/13/19 at 10:10 AM, RN #2 placed a warm towel on Resident #44's right shoulder and told her she would notify the physician of her pain.</p> <p>A Nurse's Note, dated 11/13/19 at 11:29 AM, documented the PRN Oxycodone was not effective. There was no documentation in Resident #44's record that the physician was notified of the ineffective results.</p> <p>On 11/15/19 at 2:42 PM, LPN #1 said that on 11/13/19, Resident #44 had pain that was not effectively treated with the PRN Oxycodone. LPN #1 said she left a message via text for Resident #44's physician regarding her ineffective pain relief and she asked for a stronger medication. LPN #1 said later in the shift, Resident #44 continued to have a pain rating of 8, without relief from the PRN Oxycodone. LPN #1 said she did not contact the physician via the telephone or send an additional text.</p> <p>On 11/14/19 at 4:30 PM, the DON said when Resident #44's pain was not effectively treated during the evening shift on 11/13/19, LPN #1 sent a text to the physician. The DON said she was not aware the physician had not responded to the text message until the following day. The DON said LPN #1 did not contact the physician by telephone to notify him that Resident #44 did not have effective pain relief. The DON said when a physician did not respond to a nurse's text/telephone call, the nurse was to contact the Medical Director.</p> <p>The facility failed to implement non-pharmacological interventions such as heat</p>	F 697			

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NAME OF PROVIDER OR SUPPLIER WELLSPRING HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 697	Continued From page 19 that were effective prior to using medication and when he medication was not affective to notify the physician.	F 697			
F 732 SS=C	<p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention</p>	F 732		12/18/19	

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F 732	<p>Continued From page 20 requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review and staff interview, it was determined the facility failed to ensure the daily nurse staffing information was posted daily and per shift and only included the licensed and unlicensed nursing staff directly responsible for residents' care. Additionally, the facility failed to maintain the posted daily nurse staffing hours information for a minimum of 18 months. Findings include:</p> <p>The facility's Posting Licensed and Unlicensed Direct Care Staff policy, dated 11/28/17, documented the facility posted the following information daily: total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for residents' care per shift. The policy also documented the facility retained the posted daily nurse staffing for a minimum of 18 months.</p> <p>On 11/12/19 at 12:17 PM and on 11/13/19 at 9:00 AM, the facility's daily nurse staffing hours information was observed posted on the bulletin board. The information was for 24 hours, not the current shift. The daily nurse staffing hours information, included evening and nights and was noted to have a section "Other" for each shift. The 11/13/19 daily nurse staffing information hours included "N/A, Staffing, CS, VD" under the "Other" section during the day shift and "NA" during the evening shift.</p>	F 732	<p>F732 Resident Specific No residents in this citation Other Residents Upon rounds nursing staffing is posted per policy with direct care nursing staff only.</p> <p>Facility Systems Staffing Coordinator and licensed nurses educated by Administrator and/or designee to requirements of posting and maintaining nurse staffing data for public access. The system is amended to include random review of nursing staff posting tool to include weekends and placement in a binder for 24/7 validation. Monitor The Executive Director and/or designee will audit the accuracy of posting twice weekly x 4 weeks and then weekly x 2 months. 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 12/18/2019</p>		

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F 732	<p>Continued From page 21</p> <p>On 11/14/19 at 8:29 AM, the Scheduler said "NA" on the 11/12/19 schedule was a nursing assistant and the "NA" on the 11/13/19 schedule was a hospitality aide. The Scheduler said "CS" meant Central Supply, "VD" meant Van Driver, and "Staffing" was her. The Scheduler said she would occasionally help the CNAs and nurses when she was not busy. The Scheduler said she included the Hospitality Aide in the daily staffing hours information to let the CNAs and Nurses know they had an additional person to help them but not to provide direct care to the residents.</p> <p>Records of daily staffing hours information for September 2019, October 2019 and November 2019 were then requested from the Scheduler. The "Daily Staff Posting" was for 24 hours, not per shift. Review of the facility's 9/1/19 through 11/13/19 daily nurse staffing hours information the following were found:</p> <p>*The Hospitality Aide was included in the daily nurse staffing hours information during the day shift on 9/2/19, 9/3/19, 9/5/19, 9/9/19, 9/10/19, 9/11/19, 9/13/19, 9/16/19, 9/18/19, 9/19/19, 9/20/19, 9/23/19, 9/24/19, 9/26/19, 10/1/19, 10/2/19, 10/7/19, 10/8/19, 10/10/19, 10/15/19, 10/16/19, 10/17/19, 10/21/19, 10/22/19, 10/23/19, 10/25/19, 10/28/19, 10/30/19, and 11/13/19.</p> <p>*The Hospitality Aide was included in the daily nurse staffing hours information during the evening shift on 9/3/19, 9/4/19, 9/5/19, 9/10/19, 9/11/19, 9/16/19, 9/20/19, 9/24/19, 10/7/19, 10/14/19, 10/16/19, 10/22/19, 10/28/19, 10/29/19 and 11/13/19.</p>	F 732			

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F 732	Continued From page 22 *There were no records of daily nurse staffing hours information for 9/1/19, 9/7/19, 9/8/19, 9/14/19, 9/15/19, 9/21/19, 9/22/19, 9/28/19, 9/29/19, 10/5/19, 10/6/19, 10/12/19, 10/13/19, 10/19/19, 10/20/19, 10/26/19, 10/27/19, 11/2/19, 11/3/19, 11/9/19 and 11/10/19. On 11/14/19 at 9:05 AM, the Administrator said the Hospitality Aides were included in the daily nurse staffing hours information to show there was an extra person to help in passing out water or making beds of the residents. The Administrator said the Hospitality Aides were not counted on their per patient day calculations. On 11/14/19 at 2:50 PM, the Scheduler said she included the Hospitality Aide in the daily nurse staffing hours information to let the CNAs and Nurses know they had an additional person to help. When asked about the missing sheets. The Scheduler said the missing sheets were for the weekends and she did not have them. The Scheduler said she did not work on the weekends and no daily nurse staffing hours information was posted on those days.	F 732			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		12/18/19	

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F 880	<p>Continued From page 23</p> <p>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 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</p>	F 880			

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F 880	<p>Continued From page 24</p> <p>contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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, record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate hand hygiene was performed. This was true for 2 of 15 residents (#33 and #39) reviewed for infection control practices. This deficient practice created the potential for harm if residents experienced infections from cross contamination. Findings include: The facility's policy for Hand Hygiene, dated 11/28/17, directed staff to wash hands with soap and water when visibly soiled and to use an alcohol-based hand rub for routine decontamination of hands in clinical situations, including: * After touching body fluids, whether, or not gloves were worn.</p>	F 880	<p>F880 Resident Specific Resident's #33 & #39 were both assessed to identify if the residence experienced infections from cross contamination from improper hand hygiene. No adverse outcomes occurred.</p> <p>Other Residents Residents with current infections were reviewed. None were related to hand hygiene and glove use. Facility Systems Nursing and respiratory staff were educated by Executive Director and/or designee on or before December 13, 2019 regarding infection control practices for hand hygiene, to include hand washing when donning and doffing</p>		

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F 880	<p>Continued From page 25</p> <ul style="list-style-type: none"> * Between tasks and procedures on the same patient when contaminated with body fluids to prevent cross contamination of different body sites. * When moving from a contaminated body site to a clean-body site during patient care. * After removal of gloves. <p>This policy was not followed.</p> <p>1. Resident #39 was admitted to the facility on 4/5/19, with multiple diagnoses including chronic respiratory failure and cerebral palsy.</p> <p>On 11/14/19 at 12:20 PM, RT #1 was in Resident #39's room to suction secretions from her trachea (windpipe) through her tracheostomy (an opening in the neck with a tube to the windpipe which allows air to enter the lungs). RT #1 donned gloves, removed the used HME (Heat Moisture Exchanger), and suctioned Resident #39's trachea with a single use suctioning catheter. During the suctioning, secretions landed on his glove. RT #1 said a secretion landed on the glove. RT #1 then removed both gloves, and retrieved and donned a new pair without performing hand hygiene. RT #1 then inserted a new sterile HME into Resident #39's tracheostomy. RT #1 disposed of the gloves and did not perform hand hygiene. RT #1 then used the wheelchair handles to wheel her out into the hallway. Outside the room, RT #1 sanitized his hands with hand sanitizer and then wheeled Resident #39 to the nurse's station.</p> <p>On 11/14/19 at 3:03 PM, RT #1 said he should have performed hand hygiene after he changed his his gloves when the secretions landed on his</p>	F 880	<p>gloves. The system is amended to include increased surveillance rounds for hand hygiene and glove use.</p> <p>Monitor The Executive Director and/or designee will audit direct care given by different departments twice weekly x 4 weeks and then weekly for 2 months. 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 12/18/2019</p>		

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F 880	<p>Continued From page 26</p> <p>gloves and when he finished his care with the resident.</p> <p>On 11/15/19 at 12:21 PM, UM #2 said he expected staff to perform hand hygiene after removing gloves.</p> <p>On 11/15/19 at 1:53 PM, the Infection Control Preventionist said RT #1 should have performed hand hygiene each time the gloves were removed.</p> <p>2. On 11/14/19 at 4:00 PM, LPN #3, CNA #2 and CNA #11 entered Resident #33's room to perform pericare. LPN #3 and CNA #11 performed hand hygiene before donning gloves. CNA #2 was not observed to perform hand hygiene before donning gloves. LPN #3 and CNA #11 repositioned Resident #33 to her left side as CNA #2 removed her soiled incontinence brief. CNA #2 then cleaned Resident #33's genitalia, took another wipe and cleaned her buttocks. CNA #2 then applied a new incontinence brief to Resident #33. After the pericare LPN #3 and CNA #11 removed their gloves and performed hand hygiene. CNA #2 removed his gloves and threw them in the trash can. CNA #2 then removed the used trash bag from the trash can and placed a new trash bag into the trash can. CNA #2 exited the room carrying the used trash bag in his left hand without performing hand hygiene.</p> <p>On 11/15/19 at 2:27 PM, CNA #2 said hand hygiene was performed before and after resident contact. CNA #2 said he did not remember performing hand hygiene after he provided pericare to Resident #33.</p>	F 880			

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

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F 880	Continued From page 27 On 11/15/19 at 2:34 PM, the DON said hand hygiene should be performed before and after removing gloves, between gloves changes during cares, before and after resident contact, and when going in and coming out of a resident room.	F 880			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 17, 2020

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

Provider #: 135094

Dear Ms. Mills:

On **November 12, 2019** through **November 15, 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 #ID00008221

ALLEGATION #1:

The facility does not communicate with residents' representatives, per the residents' requests.

FINDINGS #1:

Grievances and Resident Council minutes from June 2019 to November 2019 were reviewed and did not include concerns related to the facility communicating with the residents' representatives or a failure of the facility to notify the residents' representatives of situations when necessary.

Eight residents were interviewed. and none of the residents expressed concerns related to the facility not communicating with their representatives. Seven residents' representatives were also interviewed. None of the residents' representatives expressed concerns related to a lack of communication or notifications by the facility.

Five licensed nurses were interviewed. and said they notified the residents' representative when needed. Two licensed nurses said they were unable to notify the representative of one resident because the representative and the representative's children went camping and the representative was unreachable.

The Director of Nursing (DON) was interviewed and stated one resident was admitted to the facility on a Friday night for respite care. The DON stated it was the first time the resident was away from her family. The DON stated the resident expressed wanting to go home on the second day of her stay in the facility but the resident's representative and the representative's children went camping for the weekend and could not be reached, which was explained to the resident.

A hospice Social Worker (SW) was interviewed and said a hospice staff member visited the resident that weekend and explained to the resident her representative had gone camping. The SW stated the resident's representative did not have a cell phone and therefore, he was unreachable.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to honor residents' choices in movies.

FINDINGS #2:

During the survey 15 residents were observed. Eight residents said they have their choices honored by the staff.

Grievances and Resident Council minutes from June 2019 to November 2019 were reviewed and did not include concerns related to the facility not honoring resident movie choices or inappropriate or violent movies being shown in the facility.

Eight residents were interviewed and none voiced concern regarding the movies or television (TV) shows being shown in the TV area. One resident stated she was asked what type of show she wanted to watch on her television (TV) which was in her bedroom.

Two Certified Nursing Aids (CNAs) were interviewed and said they asked the residents what type of movie or TV show the residents would like to watch.

The Unit Manager (UM) was interviewed and said the facility had a theater which was accessible to the residents 24 hours a day. A Licensed Practical Nurse (LPN) stated he was told when the staff recognized a resident did not like the movie being shown, the resident was taken to his or her room. The Unit Manager also said the facility made sure the movie or program being shown on the TV located by the nurses' station was agreed upon by the residents and was appropriate for the residents.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure medications were administered as prescribed.

FINDINGS #3:

Fifteen residents' Medication Administration Records (MAR) were reviewed and there were no concerns noted. One resident's record documented the resident had refused her bedtime medications. The resident did not receive the medications, including a medication that helped her sleep. However, the MAR documented the resident slept six hours that night.

A Registered Nurse (RN) said during a telephone interview on 11/15/19, one resident knew her medications and she identified the medications before giving it to the resident. The RN said she administered the medication crushed to the resident one at a time but, she could not remember whether it was yogurt or apple sauce she used to mix the crushed medication with. The RN said when the resident refused to take her medications during her shift she called Hospice and was told she could give the resident's medication "whole" one at a time. The RN said she identified each medication before giving it to the resident but the resident did not open her mouth.

Grievances and Resident Council minutes from June 2019 to November 2019, were reviewed and did not include concerns related to the residents' medication not being administered.

Nine residents attended the group interview and no concerns were voiced regarding their medications not being administered as ordered.

Two nurses were observed at different times administering medications to three residents and there were no concerns noted.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to answer the residents' call lights in a timely manner and residents' activities of daily living (ADL) needs were not met.

FINDINGS #4:

Fifteen residents were observed in various locations, during various activities throughout the survey. There were no concerns noted regarding their grooming. Examples included, but were not limited to, the following:

- Residents observed in the dining room during meals were noted to be appropriately groomed with clean clothes and combed hair.
- One resident who communicated via eye gaze was observed every day in the Activity Room. The resident was observed to be appropriately groomed and clean.
- The care of 5 residents, who were dependent on staff with their ADL needs, were observed. No concerns were noted.

Observations of call light response times were also conducted throughout the survey. Call lights were answered in a timely manner throughout the facility and at varied hours with no concerns noted. The facility was clean and there were no unpleasant odors that would indicate a lack of care for the residents.

Fifteen residents' ADL records were reviewed and there no concerns noted.

Grievances and Resident Council minutes from June 2019 to November 2019 were reviewed and did not include concerns related to the residents' call lights not being answered in a timely manner or residents' activities of daily living needs not being met.

Debbie Mills, Administrator
January 17, 2020
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Nine residents attended the group interview with the surveyors and no concerns were voiced regarding the care they received in the facility. They all said they received their shower/baths as scheduled. Six out of seven residents voiced concern regarding their call light response time. Seven residents' representatives were also interviewed and no concerns were voiced regarding the care their family members received in the facility. None of the residents' representative expressed concern regarding call lights response time.

A Registered Nurse (RN) was interviewed on 11/15/19 at 11:21 AM, and stated a call light audit was conducted by the facility. The call light audit was reviewed and there was one incident when the call light was answered after 35 minutes. The RN stated she provided in-service training to the staff regarding answering call lights in a timely manner.

It could not be determined that the facility failed to ensure residents' ADL needs were met. The facility did fail to answer a resident's call light in a timely manner. Therefore, the allegation was substantiated. However, the facility identified the delay and provided addition training to staff. No current deficient practice was identified at the time of the survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj