STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035285	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRINGS THERAPY CENTER OF GILBERT	**3319 SOUTH MERCY ROAD GILBERT, AZ 85297**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and policy review, the facility failed to ensure MDS assessments were accurate for 4 residents (#17, #14, #22, #26). Findings include: Resident #17 was admitted to the facility on (MONTH) 15, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission MDS (Minimum Data Set) assessment dated (MONTH) 21, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Review of an informed consent form dated (MONTH) 15, (YEAR), revealed that the resident had agreed to use the sidebars for the duration of his stay to increase mobility and promote independence. Review of the admission MDS assessment dated (MONTH) 21, (YEAR), revealed the assessment was coded for the daily use of a bedrail as a restraint. An interview was conducted with the MDS Coordinator (staff #4) on (MONTH) 12, (YEAR) at 11:28 a.m. She stated that the facility was not coding side bars as a restraint back in July. She stated that she received a notice from an agency stating that anything adjacent or attached to the bed is considered a restraint, so she began coding the side bars as a restraint on the MDS assessment as instructed by the facility's administrator. The MDS Coordinator stated that the side bars were not restricting the movement of the resident, but was installed as an aid so that the resident could reposition himself and get out of bed. After referring to the Resident Assessment Instrument for the MDS assessments regarding restraints, she stated that the coding of the side bars was incorrect. -Resident #14 was admitted to the facility on (MONTH) 7, (YEAR) with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a wound note dated (MONTH) 27, (YEAR) that the resident acquired an unstageable pressure ulcer to the sacrum while in the facility. The discharge MDS assessment dated (MONTH) 1, (YEAR), revealed the resident had no pressure ulcers. An interview was conducted with the MDS Coordinator (staff #4) on (MONTH) 12, (YEAR) at 11:29 AM. Staff #4 stated that she usually looks at the wound notes for pressure ulcers. She stated that the documentation is in the clinical record that the resident did have a pressure ulcer. Staff #4 further stated that the discharge MDS assessment was coded incorrectly and that she had no explanation for it. -Resident #22 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The physician's history and physical dated (MONTH) 21, (YEAR) revealed the resident had MDD (major [MEDICAL CONDITION]). The admission MDS (minimum data set) assessment date (MONTH) 27, (YEAR), revealed a score 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact. The assessment did not include the [DIAGNOSES REDACTED].An interview was conducted on (MONTH) 11, (YEAR) with the MDS coordinator (staff #4). She stated that she reviews a resident's history and physical to obtain information to code the MDS assessments for diagnoses. She also stated that she should have coded the [DIAGNOSES REDACTED]. An interview was conducted with the administrator (staff #41) on (MONTH) 12, (YEAR) at 8:37 AM. She stated that the hospital history and physical indicates the resident has depression. The administrator stated that the facility's policy is that the MDS assessments are accurate. -Resident #26 was admitted to the facility on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. A health status progress note dated (MONTH) 2, (YEAR), revealed the resident was discharged home. Review of the discharge MDS assessment dated (MONTH) 2, (YEAR), revealed the resident was discharged to an acute hospital. An interview was conducted with the MDS Coordinator (staff #4) on (MONTH) 11, (YEAR) at 3:10 p.m. She stated that the discharge information in the MDS assessment would be based on review of the physician's discharge order. She stated that the physician's orders [REDACTED]. She stated that the discharge MDS assessment should not have been coded that the resident was discharged to an acute hospital, because the resident was discharged home. Review of the facility's policy titled Certifying Accuracy of the Resident Assessment revealed that all personnel who complete any portion of the resident assessment (MDS) must sign and certify the accuracy of that portion of the assessment. Additionally, individuals who certify false statements in a resident assessment are subject to disciplinary actions.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to provide services consistent with professional standards for one resident (#14) with a pressure ulcer. Findings include: Resident #14 was admitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The care plan dated (MONTH) 12, (YEAR), revealed the resident was at risk for impaired skin integrity related to alteration in skin turgor, altered sensation, mechanical forces, and the need for assistance with bed mobility. Interventions included monitoring the skin condition daily for changes and educating the resident on the importance of turning while in bed to avoid pressure. A Weekly Skin Check dated (MONTH) 13, (YEAR), revealed the sacrum was red, blanchable, and intact. A review of a Braden Scale dated (MONTH) 15, (YEAR) revealed the resident was at high risk for developing pressure ulcers. Review of the Weekly Skin Check dated (MONTH) 20, (YEAR), revealed to continue the current treatment to the sacrum but did not include a description of the sacrum. The admission Minimum Data Set (MDS) assessment dated (MONTH) 21, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 12, which indicated the resident had moderately impaired cognition. The assessment included the resident required extensive assistance for bed mobility and transfers. The MDS assessment also included the resident was at risk for pressure ulcers but did not have any pressure ulcers. Review of the Treatment Administration Record (TAR) dated (MONTH) (YEAR) revealed the barrier cream was applied as ordered. A physician's orders [REDACTED]. Review of a Daily Skilled Note dated (MONTH) 23, (YEAR) revealed there was redness and an open area to the sacrum. The note included daily dressing changes as ordered but did not include documentation of the condition of the wound, staging, or measurements. Additional review of the clinical record from (MONTH) 14 - 26, (YEAR) (13 days) did not reveal documentation of the wound

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) description or measurements until the resident was seen by the wound doctor on Tuesday, (MONTH) 27, (YEAR). Review of a wound note dated (MONTH) 27, (YEAR), revealed the wound was unstageable with 50% slough and 50% granulation tissue and measured 3.0 centimeters (cm) x 1.0 cm. The note also included the resident slides down when being transferred from the bed to the chair creating friction on the sacrum and that there is a new order to limit the time the resident is in the chair to one hour. The note included the resident had an APP mattress and a ROHO cushion in the wheel chair. A review of the physician's orders [REDACTED]. The Weekly Skin Check dated (MONTH) 27, (YEAR), revealed to continue the treatment as ordered to the sacrum and that the wound doctor is following. Review of the TAR dated (MONTH) (YEAR) revealed the wound treatment was administered as ordered. The resident was discharged to the hospital on (MONTH) 1, (YEAR) and readmitted on (MONTH) 5, (YEAR). Review of the physician's orders [REDACTED]. Review of the Admission Nursing Evaluation dated (MONTH) 5, (YEAR), revealed the resident had a pressure ulcer to the sacrum but did not include an assessment or measurements of the pressure ulcer. Review of the physician's orders [REDACTED]. The Weekly Skin Check dated (MONTH) 10, (YEAR) revealed an open area/pressure ulcer to the sacrum but did not include measurements or an assessment of the wound. Further review of the clinical record did not reveal documentation of the wound description or measurements until the resident was seen by the wound doctor on Tuesday, (MONTH) 11, (YEAR), six days after admission. A physician's note dated (MONTH) 11, (YEAR) revealed the sacral wound measured 1.8 cm x 0.5 cm, with 25% slough and 75% granulation tissue, no undermining or tracts, periwound is intact, no bone exposure, minimal drainage, and no odor. The note included the pressure ulcer had improved. Review of the TAR dated (MONTH) (YEAR) revealed the revealed the wound treatment was administered as ordered. An interview was conducted with a Licensed Practical Nurse (LPN/staff #83) on (MONTH) 11, (YEAR) at 1:00 PM. Staff #83 stated that when the resident was discharged to the hospital, he had a tiny open spot like a slit in the crease of his buttocks, but when he returned from the hospital it was bigger. She stated that when a skin issue is identified, she documents a note but does not describe the skin issue in detail. She stated that the wound nurse is notified and the wound nurse will evaluate, measure, and document the skin issue details. The LPN stated that this way the wound is always measured by the same person so that the documentation is accurate. The LPN stated that today is the first Tuesday since the resident was readmitted , which is the day the wound doctor makes rounds. During an interview conducted with the Assistant Director of Nursing/wound nurse (ADON/staff#3) on (MONTH) 11, (YEAR) at 3:00 PM, staff #3 stated when she is notified of a new skin issue, she will usually see the resident within 24 hours. She stated that she will notify the wound doctor who makes rounds on Tuesdays and obtain orders. Staff #3 stated that the treatment will be continued until the wound doctor sees the resident. She also stated that she keeps a binder with all the wound measurements in it. The ADON stated that on (MONTH) 22, (YEAR), the floor nurse contacted the attending physician and obtained the treatment order for the wound. An interview was conducted with the Director of Nursing (DON/#2) on (MONTH) 12, (YEAR) at 12:07 PM. The DON stated that once a pressure ulcer is identified, the nurse should obtain a treatment order from the physician and notify the wound nurse. He stated that the wound nurse will evaluate the wound to ensure proper treatment is in place and will notify the wound doctor who makes rounds on Tuesdays. The DON stated that the floor nurse needs to observe the wound every day and document their observation. He stated that the wound nurse or the wound doctor will measure and stage the wound to alleviate inaccuracies. The DON stated a baseline description of the wound was not obtained when the resident was admitted or when the resident was readmitted , but since the pressure ulcer did not get worse, the timeframe for evaluating the ulcer is not a concern. He stated that if the wound had gotten worse, then he would say the wound should have been evaluated sooner. The facility's policy regarding pressure injury/skin integrity revealed the nursing staff and the attending physician will assess and document a resident's significant risk factors for developing pressure injuries. The policy further included that in addition, the nurse shall describe and document/report the following: Full assessment of pressure injury including location, length, width and depth, presence of exudates or necrotic tissue.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, policy review, manufacturer's instructions, and the CDC (Center for Disease Control and Prevention) guidelines, the facility failed to ensure that a glucometer designated for multi-resident use was disinfected between resident use. Findings include: An observation was conducted on (MONTH) 10, (YEAR) at 12:12 p.m., of a licensed practical nurse (LPN/staff #81) using a glucometer to perform a blood glucose test on a resident. When the test was completed, staff #81 cleaned the glucometer with an alcohol pad. The LPN was then observed to use the glucometer to perform a blood glucose test on another resident. Staff #81 cleaned the glucometer with an alcohol pad prior to performing the blood glucose test on this resident and used an alcohol pad to clean the glucometer after the test. The LPN then returned the glucometer to the medication cart. During an interview conducted with staff #81 on (MONTH) 10, (YEAR) at 1:46 p.m., she stated that the glucometer was designated for multi-resident use. She stated that her process is to clean the glucometer before and after each resident use, and that she always use alcohol pads to clean the glucometer. The LPN also stated that she was not sure of the facility's policy regarding the cleaning of glucometers. An interview was conducted with the Director of Nursing (DON/staff #2) on (MONTH) 11, (YEAR) at 10:54 a.m. He stated that with the exception of residents on transmission-based precautions, the facility's glucometers were designated for multi-resident use. He stated that nurses should clean the glucometers before and after performing a blood glucose test. The DON stated that a 70% alcohol pad would be sufficient to use to clean and disinfect the glucometer. He stated that bleach wipes or similar commercially prepared wipes would be used as an added precaution to disinfect glucometers that had been used for residents on transmission-based precautions. Review of the facility's policy for cleaning and disinfecting resident care equipment revealed that reusable items such as glucometers are cleaned and disinfected between residents. The policy further included reusable equipment will be cleaned and disinfected according to current and manufacturer's standards. The manufacturer's instructions for the glucometer revealed that glucometers should be cleaned and disinfected between each resident test in order to avoid cross-contamination issues. The instructions stated to use a 70-80% [MEDICATION NAME] alcohol to clean the outside of the meter. The instructions included to disinfect the meter, use a solution of 0.5-0.6% bleach, or a commercially available 1:10 quaternary/alcohol wipe, or another EPA registered wipe that complies with CDC guidelines. The CDC guidelines revealed that infectious agents, such as the [MEDICAL CONDITION] virus (HBV) can be transmitted through indirect contact transmission, even in the absence of visible blood. Indirect contact transmission is defined as the transfer of an infectious agent (e.g. HBV) from one patient to another through a contaminated intermediate object (e.g. blood glucose meter). The CDC guidelines revealed a reference to FDA instructions which included meters must be properly cleaned and disinfected after every use. The disinfection solvent you choose should be effective [MEDICAL CONDITION].[MEDICAL CONDITION], and HBV. Please note that 70% [MEDICATION NAME] solutions are not effective against [MEDICAL CONDITION] bloodborne pathogens.