STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035293	A. BUILDING _____ B. WING _____	**07/03/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLSPRINGS THERAPY CENTER OF PHOENIX	**3008 NORTH 3RD STREET PHOENIX, AZ 85012**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure that advance directives were accurately documented for 1 of 36 sampled residents (#2). Failing to have accurate documentation for advanced directives could result in performing emergency treatment against a resident's wishes. Findings include: Resident #2 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. A review of the resident's clinical record revealed a Do Not Resuscitate (DNR) medical care directive dated (MONTH) 6, 2019, which was signed by the resident's family member and a licensed health care provider. However, review of the physicians' orders dated (MONTH) 1, 2019 revealed documentation that the resident was a Full Code status. The orders were signed by the resident's physician. On (MONTH) 1, 2019 at 3:25 p.m., an interview was conduced with a Licensed Practical Nurse (staff #90). Staff #90 stated that the resident's advanced directives and the doctors orders should be the same to prevent confusion. On (MONTH) 1, 2019 at 3:31 p.m., an interview was conduced with the Director of Nursing (DON/staff #37). Staff #37 stated that the resident's advanced directives should reflect the resident's wishes and the doctor's orders should match the resident's documented desired DNR status. Review of the Advanced Directives policy revealed that advanced directives will be respected in accordance with state law and facility policy. The policy included that the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The DON or designee will notify the attending physician of the advanced directives, so that appropriate orders can be documented in the resident's medical record. The nurse supervisor will inform emergency personnel of a resident's advanced directives regarding treatment options and provide a copy of such directive.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#184) with a wound VAC (Vacuum-Assisted Closure) was provided wound care in accordance with professional standards of practice. The deficient practice could result in delayed healing of the wound. Findings include: Resident #184 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 27, (YEAR). A review of the hospital discharge orders revealed no orders regarding a wound VAC. Review of the physician's orders [REDACTED]. The order did not include settings for the wound VAC or whether it should be intermittent or continuous. A review of the baseline care plan dated (MONTH) 20, (YEAR) revealed the resident had an abdominal wound with a wound VAC and to change the wound VAC on Monday, Wednesday, and Friday. Continued review of the physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed the physician orders [REDACTED]. Additional review of the (MONTH) (YEAR) TAR revealed documentation on (MONTH) 26, (YEAR) to see the nurse notes regarding changing the wound VAC. Review of the nursing notes dated (MONTH) 26, (YEAR) revealed the resident had gone out for a follow up appointment and that when the resident returned to the facility, the resident no longer had the wound VAC. The notes also included there was a new order for dressing changes to the wound. Review of the physician order [REDACTED]. In an interview conducted with the Assistant Director of Nursing (ADON/staff #117) on (MONTH) 3, 2019 at 9:07 AM, the ADON stated that he reviews admission orders [REDACTED]. He also stated the orders should include the settings and whether the wound VAC is continuous or intermittent. He further stated that the nurses change the wound VAC dressing except for on Wednesdays when the wound doctor makes round. The ADON stated the wound doctor changes the dressings on Wednesdays. The ADON stated that the facility stocks wound VAC dressing supplies. In an interview conducted with the Director of Nursing (DON/staff #37) on (MONTH) 3, 2019 at 9:44 a.m., she said that residents that are discharged from the hospital with a wound VAC, has orders for the wound VAC on the hospital discharge orders. The DON stated that the hospital discharge orders for the wound VAC would remain in effect until the wound doctor made his round. She stated the wound doctor would make recommendations regarding the wound VAC. The DON stated that on (MONTH) 26, (YEAR) when the resident went out for a follow up appointment with the surgeon, the surgeon discontinued the wound VAC. She also stated that was the day the wound doctor made rounds and recommended discontinuing the wound VAC. The facility's policy titled Wound VAC revealed residents with orders for a Wound VAC will have device applied per physician order. The policy included nursing will be responsible for changing settings/dressing per physician protocol. The policy also included documentation of application, and settings of the wound VAC will be recorded in the clinical record. The policy revealed the wound VAC protocol will be added to the TAR, the Licensed Nurse will initial the TAR indicating the wound VAC was applied and used per order/protocol.

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

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.