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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 reflects the findings of the Department of Public Health during a Complaint Investigation. Complaint Number : CA00506863 - Substantiated Representing the Department of Public Health Surveyor ID Number : 04945, HFEN The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Highest S/S: G	F 000	This Plan of Correction serves as the Facility's credible of allegation of compliance.	2017 FEB -7 PM 2:12
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a resident's (Resident 1) care plan for being at risk for constipation/fecal impaction (a mass of dry, hard stool that will not pass out of the colon or rectum) by failing to: 1. Monitor the bowel movements (BM) every shift	F 309	F 309 1. Resident #1 is no longer in the facility. Upon learning of the alleged deficient practice, the DON and the MRD reviewed the bowel elimination records of all residents; no similar deficient practice was identified. 2. All residents have the potential to be affected by the same alleged deficient practice. The DON and the Unit Managers reviewed the medical records of residents that have a potential likelihood for constipation and bowel impaction derived from the use of opiates, and other factors (post-surgery, lack of mobility, etc.). Residents that were identified were initiated on a bowel management program that includes monitoring bowel sounds, bowel discomfort, bowel distention, frequency and consistency of bowel movement every shift. 3. The bowel management program now includes among others documentation in the eMAR for monitoring bowel sounds, bowel distention, bowel frequency and	

LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH RECEIVED LICENSING & CERTIFICATION

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

Charles A Fine | Administrator | 02-07-17

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.

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 1 and record in the flow sheet. 2. Observe closely for any signs and symptoms of fecal impaction such as distended abdomen, nausea, and vomiting. 3. Administer stool softener per the physician's order. 4. Review the medications for possible cause of constipation. 5. Encourage fluid intake of 1800 milliliters (ml) or more in 24 hours. This failed practice resulted in Resident 1's transfer to the general acute care hospital (GACH) where she died the following day with the final diagnoses that included nausea, vomiting, severe dehydration (when the loss of body fluids, mostly water, exceeds the amount that is taken in), and early small bowel obstruction (blockage of the intestines which prevents the products of digestion to pass through) versus possible ileus obstruction (intestinal obstruction) versus severe obstipation (severe or complete constipation). Findings: On November 4, 2016, an unannounced complaint visit was made to the facility to investigate an allegation that Resident 1 did not have a bowel movement (BM) while in the skilled nursing facility (SNF), for four days. She was transferred to the GACH for abdominal distention on February 16, 2015, and died the following day. A review of Resident 1's SNF medical record indicated she was admitted to the facility on	F 309	consistency, and any abnormal findings will be relayed to the attending MD by the charge nurse. • The DON and DSD in-serviced licensed nurses on February 2 & 3, 2017 regarding bowel management, constipation and fecal impaction and identifying potential high risk residents. This in-service included the implementation of monitoring bowel sounds, bowel patterns, bowel consistency and frequency every shift in the eMAR and taking appropriate measures to notify abnormalities to attending physician for interventions. • On February 2 & 3, 2017 a similar in-service was provided for CNA's by the DSD in identifying the absence of bowel movements beyond 3 days when caring for assigned residents. Notification of lack of bowel movement will be recorded in CNA tasks on their ADL Flow records and effective communication and notification to licensed nurses. 4. The effectiveness of this POC will be monitored by the Unit Managers by daily record review of CNA's bowel management records and daily ADL care flow records. This review will effectively identify residents that may benefit from a varied combination of laxative, stool softeners and diet modification • Admission Nurses will ensure that new admits with predisposed factors leading	

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 2 February 11, 2015, at 4:30 pm, from the GACH following a fall at home which resulted in an L1 compression fracture (collapse of the upper vertebra of the lumbar spine) requiring physical therapy and pain control with no surgical intervention. Her admission diagnoses included a fracture of the lumbar vertebra, schizoaffective disorder [persistent symptoms resembling schizophrenia (break with reality and feeling sad and fatigued)], hypothyroidism (lack of thyroid production resulting in fatigue and weight gain), diabetes type II (a chronic disorder of carbohydrate metabolism due to a lack of insulin), hyperlipidemia (an increase of fat in the blood), anemia (a reduction in the number of circulating red blood cells), dementia without behavioral disturbances (intellectual function impairment), and major depression disorder (altered mood). The Nurses' Admission Record dated February 11, 2015, indicated in the notes that Resident 1 was continent of bowel and bladder, alert and verbally responsive. The Bowel and Bladder Assessment dated February 11, 2015, indicated Resident 1 was continent. Resident 1's care plan dated February 11, 2015, identified the problem of at risk for constipation/fecal impaction resulting from Resident 1's impaired mobility, poor fluid intake, intake of psychotic medications and narcotics (pain medication). The goal was for Resident 1 to have a bowel movement at least every three days. The intervention plan was to monitor Resident 1's bowel movements every shift and record in the flow sheet, review medication for possible cause of constipation, give stool softener per the physician's order, encourage fluid intake of 1800 ml or more in 24 hours, and give laxative	F 309	to constipation, fecal impaction (i.e. opiates, post-surgery, lack of mobility, etc.) will be identified upon admission. Physician orders are transcribed for appropriate bowel management. Admission nurses will also transcribe monitoring bowel sounds, bowel consistency, bowel frequency every shift in the eMAR. • In addition, the DON and MRD will review daily all admission records with the new admissions. The MRD/designee will further conduct a daily qualitative audits to identify residents who had no bowel movement over 3 days to ensure that the Bowel Management program is implemented accordingly. • Significant findings will be submitted to the DON and Administrator and shall be forwarded to the QAPI Committee for trending and root cause analysis, recommendation, corrective action and for CQI. 5. The corrective action will be completed on February 13, 2017.	02/13/2017

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 3 daily or as needed per the physician's order. The plan indicated to observe closely for any signs and symptoms of fecal impaction, distended abdomen, or vomiting, and notify the physician. Resident 1 had physician orders as follows: 1. Milk of Magnesia Concentrate suspension (MOM - stool softener) - give 30 cubic centimeter (cc) as needed daily if no BM in three days dated February 11, 2015. 2. Dulcolax Suppository (a laxative that promotes bowel movement) - insert 1 suppository rectally as needed for constipation if no results 8 hours after giving MOM dated February 11, 2015. 3. Fleet Enema (a laxative that promotes bowel movement) - insert 1 application rectally as needed for constipation if no result from Dulcolax suppository dated February 11, 2015. 4. Lactulose (solution use for treatment of constipation) 30 cc per oral (PO - mouth) twice a day dated February 12, 2015. 5. Norco tablet 5/325 PO every eight hours routine dated February 12, 2015. [Norco is an analgesic medication and its side effects included constipation. (Nursing Drug handbook, 2015, Pages 704-705)]. 6. Abilify tablet 5 milligrams (mgs) by mouth at bedtime dated February 12, 2015. [Abilify is an antipsychotic and its side effects included constipation. (Nursing Drug handbook, 2015, Pages 148-150)]. 7. Omeprazole 1 tab 20 mgs. PO daily for	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 4 stomach upset dated February 13, 2015. [Omeprazole is an antiulcer drug and its side effects included constipation. (Nursing Drug handbook, 2015, Pages 1046-1047)]. 8. Zofran 4 mgs PO for nausea/vomiting dated February 15, 2015 (no time). The Nutritional Assessment Screening Data sheet dated February 11, 2015, and reviewed by the Registered Dietitian on February 16, 2015, indicated Resident 1 was at risk of constipation and that she was on medication for bowel management. The fluid requirement assessment was left blank. A review of the Medication Administration Record (MAR) for the month of February 2015, indicated Lactulose was only administered once (morning dose was circled), rather than twice on February 13, 2015, as ordered by the physician, and twice daily on February 14 and 15, 2015. There was no documented evidence that Resident 1 was administered MOM, Dulcolax or a Fleet Enema, when Resident 1 did not have a BM, as ordered by the physician and as indicated in the care plan. The Nursing Assistant Daily Flow sheet for the three shifts dated February 11 to 15, 2015, indicated Resident 1 had no bowel movement. On the back of the flow sheet, dated February 15, 2015, (no time) indicated Resident 1 had no BM for five days; charge nurse notified. An added note indicated the resident receives Lactulose 30 cc twice daily. "MOM also given," which did not match the previous MAR documentation. A review of Resident 1's "Elimination Pattern Assessment" data dated February 11 to 15, 2015,	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 5 indicated Resident 1 had no bowel movements. The Daily Narrative Nurses Notes dated February 12, 13, 14, and 15, 2015, on the 3 pm to 11 pm shift, under General Description for last bowel movement, was left blank. On February 15, 2015, (no time indicated), it was noted that Resident 1 vomited twice, and Zofran for nausea and vomiting was given. (The adverse reaction to Zofran is constipation.) A review of Resident 1's Intake and Output (I&O) Record from February 11 to February 16, 2015, indicated the fluid intake given ranged from 1080 to 1160 ml. The recommended fluid intake was left blank. On December 29, 2016, at 9:30 am, during an interview with the Assistant Director of Nurses, he stated that the I&O records were completed by a Certified Nursing Assistant (CNA). He stated the I&O records were supposed to be tallied by a licensed nurse at the end of the shift. On December 29, 2016, at 11:45 am, in a telephone interview with the licensed nurse (LN 1), she stated Resident 1 received medication for constipation, but did not know what medication was given, or if she documented on the MAR. She stated she remembered Resident 1 did not have a BM (before being sent to the hospital). In a telephone interview with the Director of Nurses on January 9, 2017, at 3:40 pm, she stated Resident 1's care plan indicated to encourage 1800 ml or more of fluids per day. She stated the care plan interventions should have been implemented.	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 6 A review of Resident 1's Licensed Personnel Weekly Progress Notes for February 2015 indicated the following: 1. On February 14, 2015, on the 11 pm to 7 am shift, Resident 1 complained of pain at a level of 6 out of 10 (0 being no pain and 10 being the worst possible pain) and was given Norco. 2. On February 14, 2015, (no time documented, the next entry) Resident 1 complained of pain, medicated as ordered with therapeutic effect. 3. On February 15, 2015, (no time indicated) Resident 1 had an episode of vomiting (10 cc of watery emesis white in color). Resident 1 refused to take anything for nausea. 4. On February 16, 2015 at 5:30 am, Resident 1 was sent to the hospital for further evaluation after nausea and vomiting with brown colored emesis, abdominal distention, and no bowel sounds (the gurgling, rumbling, or growling noises from the abdomen caused by the muscular contractions that moves the contents of the stomach and intestines downward) heard over all quadrants (listening with a stethascope to the four regions of the abdomen and lower stomach area). There was no documentation in the Licensed Personnel Weekly Progress Notes from February 12 to 16, 2015, that Resident 1 was administered MOM, Dulcolax or a Fleet Enema as ordered by the physician. The Nurses Progress Note & Care Plan dated February 16, 2015, at 1:00 am, indicated Resident 1 still complained of nausea and	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 7 vomiting with three episodes of brown emesis and had no bowel movement. Dulcolax suppository was given and a digital check was performed without stool present. At 3:20 am, the resident still had no bowel movement, complained of discomfort, and her abdomen was distended with no bowel sounds in four quadrants per Registered Nurse supervisor. Fleet Enema was given (no documentation of results). At 4:00 am, the note indicated the resident was getting anxious and requested to go to the hospital. Resident 1 still did not have a bowel movement by 4:45 am. The physician ordered to transfer Resident 1 to the hospital. A Change of Condition SBAR-GI Symptoms (Situation, background, assessment, request-gastrointestinal) form dated February 16, 2015 at 4:49 am, indicated Resident 1 was having nausea, vomiting, constipation, abdominal distention, and no bowel sounds. The physician was notified at 4:49 am. On December 29, 2016 at 9:15 am, during an interview, the registered nurse (RN 1) stated that on February 16, 2015, LN 1 requested her to assess Resident 1 because of the resident's request to go to the hospital. Resident 1 had no bowel sounds in all four quadrants and was sent to the hospital. There was no documented evidence in the medical record that the licensed nurses implemented Resident 1's care plan interventions, including monitoring for BM every shift and documenting; evaluating the documentation when Resident 1 had no BM; and assessing for abdominal distention and for the presence or lack of bowel sounds, until February	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 8 16, 2015, at 3:20 am. There was no documentation to indicate Resident 1's medications were reviewed for possible cause of constipation according to the care plan to prevent constipation/fecal impaction. During a telephone interview on January 9, 2017, at 3:40 pm, with the Director of Nurses (DON) and Assistant DON, regarding Resident 1's death, they stated the CNAs are supposed to document a resident's bowel movements. The DON stated that MOM was not given to Resident 1 on February 14, 2015, the third day of no BM, as per the physician orders. The DON stated since the resident was only in the facility for four days, the medications had not been reviewed by the pharmacist. A review of the facility's undated Policy and Procedure, titled "Documentation" indicated all charting includes the date and time, indicating a.m. or p.m.; and documentation includes all assessments of residents, all interventions taken, all communications made, the resident's response, and progress or lack of progress toward the goals of the written Care Plan. The section titled "Licensed Nurse Documentation Requirements" indicated for new admissions, complete documentation every shift for 72 hours, addressing pertinent resident problems and initiating the preliminary Care Plan. A review of the Emergency Physician Record indicated Resident 1 arrived at the emergency room on February 16, 2015, at 5:50 am, for nausea, vomiting, and the last BM was four days. The GACH Emergency Record dated February 16, 2015, indicated Resident 1 had mild level of respiratory distress and vomiting coffee ground	F 309		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.16TH ST. WEST LANCASTER, CA 93534

(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 309	Continued From page 9 emesis. A nasal gastric tube (a tube pass through the nares down to the stomach) was inserted with an initial output of 400 ml of brown fluid. The CT (computed tomograpy - takes images of the body using x-rays) scan report of Resident 1's abdomen and pelvis, indicated diffusely distended small bowel loops and stomach suggesting either partial/early small bowel obstruction versus severe ileus. A review of the GACH Discharge Summary indicated Resident 1 was admitted to the emergency department with severe nausea and vomiting on February 16, 2015. Critical care was initiated. Resident 1's sodium was profoundly low at 116, and was given a bolus (rapid) with normal saline fluid resuscitation. Resident 1 deteriorated overnight and died at 1:18 am on February 17, 2015. The final diagnoses included nausea, vomiting, severe dehydration, acute kidney injury, early small bowel obstruction versus possible ileus versus severe obstipation, and sepsis (life-threatening illness caused by the body's response to an infection).	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F514 1) Resident #1 is no longer in the facility. Upon learning of the alleged deficient practice, the DON, QA and MRD/designee did a review of MAR's of all residents to ensure documentation consistency in the eMAR's. No similar alleged deficient practice was identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44446 NO.15TH ST. WEST LANCASTER, CA 93534

(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 514	Continued From page 10 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain residents medical records that were complete and accurately documented, and follow its policy and procedure for Medication Administration or titled "Documentation" when documenting medication administration. The medications were not charted as given on Resident 1's medication administration record (MAR). The deficient practice had the potential for a resident not receiving medications as ordered. Findings: A review of the medical record revealed Resident 1 was admitted to the facility on February 11, 2015, at 4:30 pm, from the general acute care hospital (GACH) following a fall at home which resulted in lumbar compression fracture (collapse of the upper vertebra of the lumbar spine) requiring physical therapy and pain control with no surgical intervention. Her admission diagnoses included a fracture of the lumbar vertebra, schizoaffective disorder [persistent symptoms resembling schizophrenia (break with reality and feeling sad and fatigued)], hypothyroidism (lack of thyroid production resulting in fatigue and weight gain), diabetes type II (a chronic disorder of carbohydrate metabolism due to a lack of insulin), hyperlipidemia (an increase of fat in the blood), anemia (a reduction in the number of circulating red blood cells), dementia without behavioral disturbances (intellectual function impairment),	F 514	2) All residents are at risk to be affected by the noted alleged deficient practice. On February 02, 2017 the Medical Records Designees conducted an audit sweep of the medication administration records to identify similar deficient practice. No similar alleged deficient practice was identified. 3) The facility established a 3 way medication administration records drug check and audit that coincides with the weekly summary schedule. On February 02, 2017 DON and QA conducted an in-service to licensed nurses regarding the consistency, accuracy and completeness of documentation in the medication administration records to reflect medication administration in the care of all residents. This is to ensure and eliminate medication errors and adverse reaction related to lack of concise documentation. On February 02, 2017 a similar in-service was given by Medical Records Director and QA coordinator to the Medical Record Designees. This in-service addressed the audit aspect and timeliness in identifying the consistency, accuracy and completeness of licensed documentation in the eMAR's. 4) The implementation of the plan of correction will be monitored by the Unit Managers, RN Supervisors and the licensed nurses on daily basis by conducting a 3-way audit of the eMAR's of residents that are schedule for weekly summary documentation each shift. The	

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 514	Continued From page 11 and major depression disorder (altered mood). The resident had physician orders as follows: 1. Milk of Magnesia Concentrate suspension (MOM - stool softener) - give 30 cubic centimeter (CC) as needed daily if no BM in three days dated February 11, 2015. 2. Dulcolax Suppository (a laxative that promotes bowel movement) - insert 1 suppository rectally as needed for constipation if no results 8 hours after giving MOM dated February 11, 2016. 3. Fleet Enema (a laxative that promotes bowel movement) - insert 1 application rectally as needed for constipation if no result from Dulcolax suppository dated February 11, 2016. 4. Lactulose (solution use for treatment of constipation) 30 cc per oral (PO - mouth) twice a day dated February 12, 2015. A review of the Medication Administration Record (MAR) for the month of February 2015, indicated Resident 1 was not administered MOM, Dulcolax or Fleet Enema. Lactulose was administered once (morning dose was circled) instead of twice on February 13, 2015, and twice daily on February 14 and 15, 2015. On December 29, 2016 at 11:45 am, in a phone interview with a licensed nurse (LN 1), she stated that Resident 1 received medication for constipation but did not remember what medication was given. She did not remember if she documented on the MAR. The Daily Narrative Nurses Notes dated February	F 514	DON, QA Coordinator, Medical Records Director will ensure effectiveness of the plan of correction thru biweekly eMAR review. In addition, the Pharmacy Consultant and Medical Records Consultant will monitor compliance during their schedule visit. Significant findings will be submitted to the administrator and will be forwarded to the QA & A Committee for trending analysis., corrective action and for CQI. 5) Corrective action will be in place on or before February 28, 2017.	02/282017

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 514	Continued From page 12 12, 13, 14, and 15, 2015 on the 3 to 11 shift under General Description for last BM was left blank. On February 15, 2015 (no time), it was noted that Resident 1 vomited twice. There was documentation on the back of the Nursing Assistant Daily Flow sheet dated February 15, 2015 (no time), that Resident 1 had no BM for 5 days and the charge nurse was notified. The resident was receiving Lactulose 30 cc twice daily and MOM also given (no time when it was given). The Licensed Personnel Weekly Progress Notes dated February 14, 2015, (no time) indicated Resident 1 complained of pain, medicated as ordered with therapeutic effect. On February 15, 2015, (no time) the resident had an episode of vomiting (10cc of watery emesis white in color). Resident 1's Nurses Progress Note & Care Plan dated February 16, 2015, indicated that a Fleet Enema was given, but the time was not documented. There was no documented evidence in Resident 1's medical records that the licensed nurses were monitoring the resident's bowel movement activity, checking the resident's abdomen for the presence of abdominal distention and bowel sounds until February 16, 2015 at 3:20 am. A review of the facility's undated Policy and Procedure, titled "Documentation" indicated all charting includes the date and time, indicating a.m. or p.m.; and documentation includes all assessments of residents, all interventions taken, all communications made, the resident's response, and progress or lack of progress	F 514		

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

PRINTED: 01/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 514	Continued From page 13 toward the goals of the written Care Plan. The section titled "Licensed Nurse Documentation Requirements" indicated for new admissions, complete documentation every shift for 72 hours, addressing pertinent resident problems and initiating the preliminary Care Plan. A review of the facility's Policy and Procedure, titled "Medication Administration" indicates to chart the medication given.	F 514		

accepted 3/21/17

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

PRINTED: 03/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 reflects the findings of the Department of Public Health during an Abbreviated Survey Revisit: Complaint Number: CA00506863 - Not in Compliance Representing the Department of Public Health: Surveyor Federal I.D. Number: 36500, RN, HFEN The inspection was limited to the specific complaint and does not represent the findings of a full inspection of the facility. Highest S/S: D F309 - Repeat Deficiency	{F 000}	This Plan of Correction serves as the Facility's credible allegation of compliance: F 309 1. Resident 1 remains at the facility in stable condition. Licensed Nurses are now following the Physician's orders to hold stool softeners and laxatives when the resident has an episode of loose stools.	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the nursing staff failed to follow the physician's order to hold medications [Docusate Sodium-stool softener and Senna- laxative that	{F 309}	2. All residents who require the use of laxative or stool softeners have the potential to be affected by same alleged deficient practice. On 03/24/2017, the DON and QA nurse reviewed the medication administration record and Physician Orders for those residents who are receiving stool softeners and laxatives. The attending physician for identified residents was notified and an order was received to monitor the residents for episodes of loose stools prior to administering the stool softener or laxatives every shift. The order for monitoring for loose stools was placed on the resident's medications administration record.	

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

Administrator 03-27-17

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.

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

PRINTED: 03/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309}	Continued From page 1 promotes bowel movement] for bowel management when the resident was having loose stools for one out of two sample residents (1). This deficient practice placed the resident at risk for having excessive loose stools due to the failure of the nursing staff to hold the laxative medications. Findings: A review of the admission record indicated Resident 1 was originally admitted to the skilled nursing facility (SNF) on November 15, 2016, and readmitted on January 13, 2017, with diagnoses that included fracture of the left pubis, dementia (decline in mental ability that interferes with daily life), anemia (lack of healthy red blood cells in the blood), age-related osteoporosis (a condition in which bones become weak and fragile), and stress incontinence (inability to control the urge to urinate). The Minimum Data Set [MDS-a comprehensive assessment and care screening tool] dated December 19, 2016, indicated Resident 1 had moderately impaired cognitive skills (the act or process of knowing, perceiving), required extensive assistance with two-person physical assist with bed mobility, transfer, and toilet use. The MDS also indicated Resident 1 was frequently incontinent of bowel. The Nurse's Skilled Notes dated February 25, 2017, indicated Resident 1 was frequently incontinent of bowel and bladder. On February 27, 2017 at approximately 8:00 a.m., Resident 1 was observed awake in bed.	{F 309}	3. On 03/21/2017 to 03/24/2017 the DON, DSD and QA nurse provided in-service training to licensed nurses and nursing assistants on the importance of reporting episodes of loose stools immediately to the charge nurse. It was explained to the CNAs that some residents take laxatives daily and it is important for the charge nurse to be informed in a timely manner so that the laxative can be held for that shift. The CNAs were directed to contact the Charge nurses immediately after a resident has a bowel movement. The Charge Nurses were directed to contact the RN Supervisors anytime there is a change of condition for a resident. The RN Supervisors were directed to assess all residents when a change of condition occurs, and contact the physician as required. The DON informed the licensed nurses that there is now a physician's order to monitor residents for loose stools prior to administering stool softeners or laxative and that the order will be placed on the resident's medication administration record for those residents receiving stool softeners and laxatives.	

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

PRINTED: 03/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309}	Continued From page 2 When Resident 1 was asked how she was doing, Resident 1 stated, "I need help, I'm constipated," while clutching her stomach. The Licensed Vocational Nurse (LVN 1), who was outside the resident's room was made aware of the resident's complaint. LVN 1 stated Resident 1 is always complaining she is constipated, and is currently having a bowel movement. Resident 1 had physician orders as follows: 1. Docusate Sodium (stool softener) Tablet 100 milligram (mg) by mouth two times a day for bowel management. Give 100 mg/2 tablets. Hold for loose stool. 2. Senna (Sennosides) tablet 8.6 mg. Give 17.2 mg. by mouth at bedtime for bowel management. Give 8.6 mg/2 tablets. Hold for loose stool. The Certified Nursing Assistant (CNA) Point of Care Flow sheet on bowel and bladder elimination dated February 23, 2017 to 24, 2017, indicated Resident 1 had five successive loose/diarrhea stools. The date, time, and size of the loose stools were as follows: 1. February 23, 2017 at 10:23 p.m. (large loose stool). 2. February 24, 2017 at 12:44 a.m. (medium loose stool). 3. February 24, 2017 at 5:04 a.m. (small loose stool). 4. February 24, 2017 at 10:46 a.m. (medium loose stool).	{F 309}	4. The RN supervisors will monitor compliance on every shift daily by directly observing all residents with changes in condition. The RN supervisor will maintain close communication with the licensed nurses and CNAs with regards to change of condition and do record review to ensure that residents are properly assessed when they experience episodes of loose stools, that the physician's orders to hold laxative and stool softeners are followed, and that resident's physician are notified when he or she has changes in condition. Findings will be addressed with staff involved for immediate corrective action. Significant findings will be submitted to the administrator and will be forwarded to the QA & A Committee for trending analysis, corrective action and for CQI. 5. Corrective action will be in placed on or before 03/28/2017	03/28/2017

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

PRINTED: 03/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 309}	Continued From page 3 5. February 24, 2017 at 1:18 p.m. (small loose stool). A review of the Medication Administration Record (MAR) for the month of February 2017, indicated Resident 1 was administered Docusate Sodium tablet 200 mg at 9 a.m. and 5 p.m. and Senna tablet 17. 2 mg at bedtime on February 24, 2017. A review of the Nursing Progress Notes in the presence of Licensed Vocational 2 (LVN 2) on February 27, 2017 at approximately 2:00 p.m., indicated there was no documentation of Resident 1's episodes of loose stools nor did the notes indicate the resident's physician was notified of the resident's change in condition. During an interview with LVN 2 at the time of the review of Resident 1's clinical records, LVN 2 stated the physician should have been notified and the laxative medications held (Docusate Sodium and Senna) due to Resident 1 having loose stools. During another interview with LVN 3 on the same day at approximately 3:00 p.m., LVN 3 stated nursing staff should have checked the CNA's documentation on bowel and bladder before administering the medications because the physician's order indicated for licensed nurses to hold the medications (Docusate Sodium and Senna) if the resident was having loose stools. A review of the facility's undated policy and procedure titled "Change in Condition: When to report to the MD/NP (Nurse Practitioner)/PA (Physician Assistant) indicated acute onset of three or more episodes of loose stools should be reported immediately.	{F 309}		

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

PRINTED: 03/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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

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

PRINTED: 04/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	R-C 03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

(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 reflects the findings of the Department of Public Health during an Abbreviated second revisit survey: Complaint Number: CA00506863 Representing the Department of Public Health: Surveyor Federal I.D. Number: 36500, RN, HFEN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 04-07-17

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.